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Missouri Medicine

Journal of the Missouri State Medical Association July 1992

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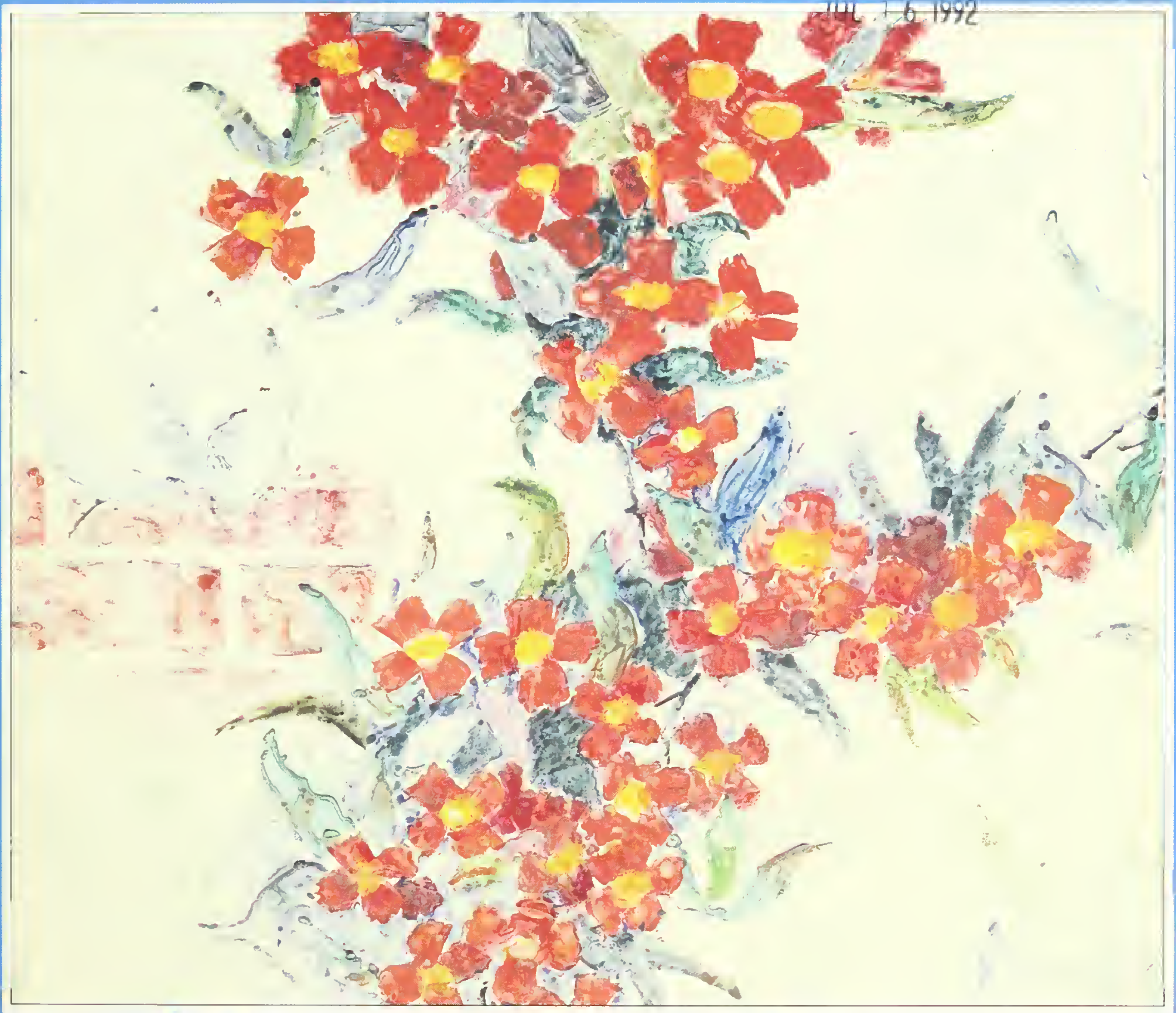

In this Issue:

1992 Annual Convention Issue

- ☐ Minutes of the House of Delegates
- ☐ Resolutions
- ☐ Convention Registration
- ☐ Committee and Commission Reports

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Owned and edited since 1904 by the Missouri State Medical Association. *Missouri Medicine*, Journal of the Missouri State Medical Association, is published monthly at 113 Madison, Jefferson City, Missouri 65102. Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices. Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept. P.O. Box 1028, Jefferson City, MO 65102.

The subscription price per year for nonmembers is $20.00. Annual subscription for members is included in the annual membership dues. The international subscription price is $40.00. Single copies are $4.00 and the cost of copies of the annual August Directory issue is $15.00.

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Printed by the Ovid Bell Press, Inc., Fulton, Missouri 65251.

CONTENTS

VOLUME 89, NUMBER 7

Missouri State Medical Association 134th Annual Convention

Minutes of House of Delegates 393

Presidential Inauguration Speech 403

President's Message 407

Auxiliary Report 411

Resolutions of the House of Delegates 414

Committee and Commission Reports 425

Convention Registration by Districts 436

Summary of Council Minutes (1991-1992) 441

Courtesy Resolution on Deceased Members 444

Missouri State Medical Foundation 446

Exhibitors 447

In Memoriam 449

Classified Advertisements 450

Information for Contributors 453

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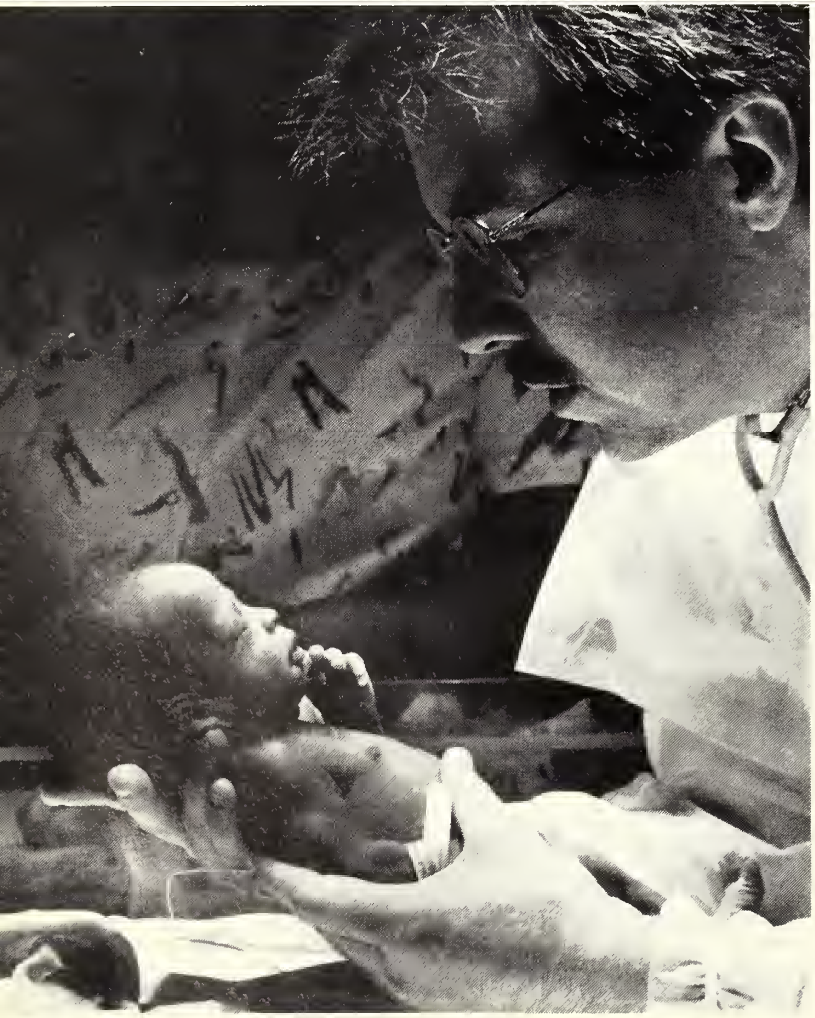

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Vol. 89, No. 7 July 1992

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July Cover

John W. Fries, M.D., St. Louis, supplied the artwork for this month's issue. Dr. Fries' work has been reproduced on several medical journal covers, including *JAMA, St. Louis Metropolitan Medicine,* and, of course, *Missouri Medicine.* He calls this watercolor, *"Garden Wall"*. Before retiring from practice in 1988, Dr. Fries was the director of radiology at St. Anthony's Medical Center.

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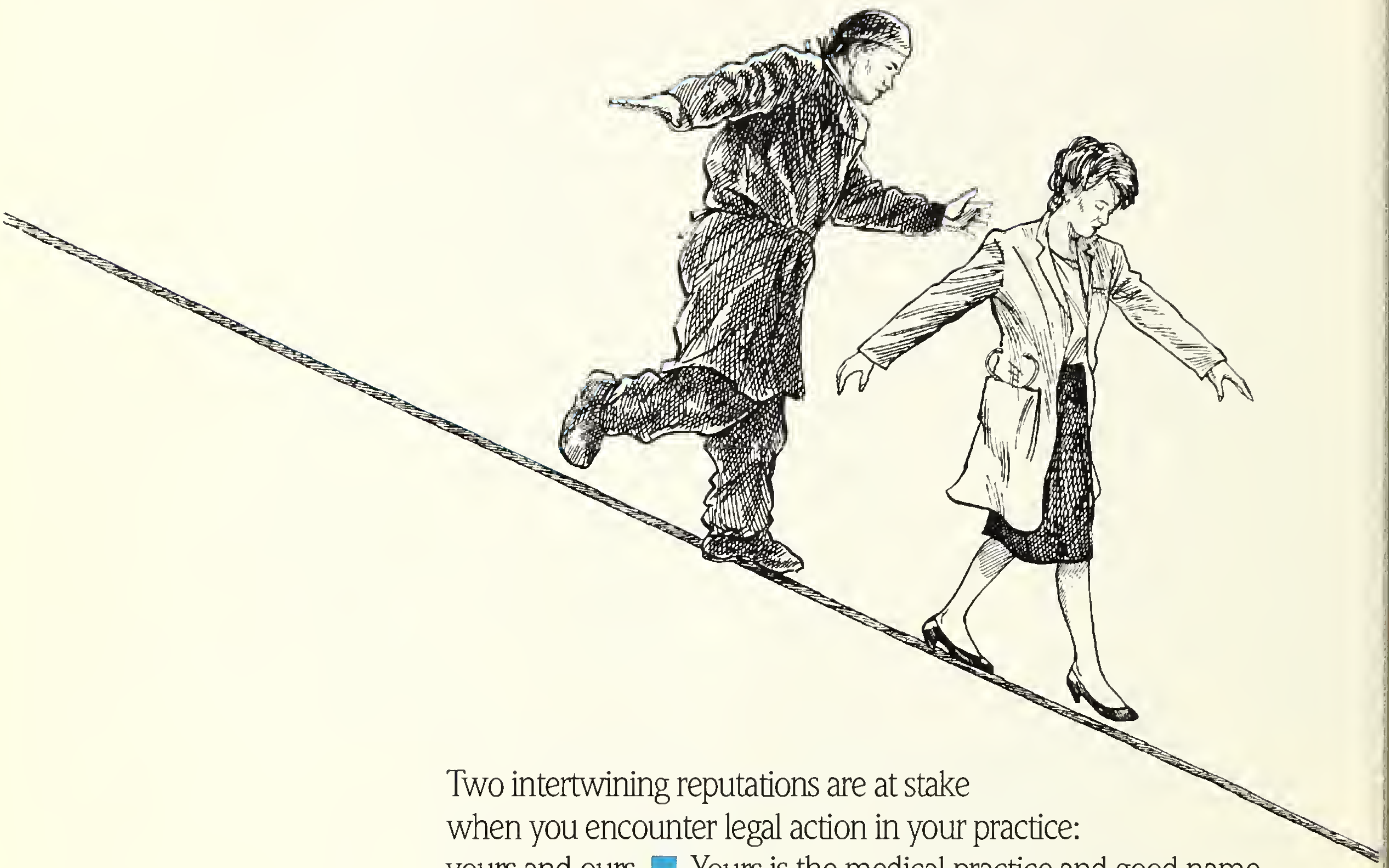

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134th Annual Convention
Missouri State Medical Association

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April 9-12, 1992

The First Session of the MSMA House of Delegates was called to order at 10:00 a.m., Thursday, April 9, 1992 by Speaker of the House, Jo-Ellyn M. Ryall, M.D. The following officers and delegates were present during the 134th Annual Meeting:

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Mineral Area	Robert A. Huckstep, Farmington
SEMO	Don Cento, Sikeston
SEMO	Ken Dempsey, Sikeston
SEMO	Theodore Roberts, Sikeston

Delegates-At-Large

Jo-Ellyn M. Ryall, Speaker, St. Louis
James B. Wolfe, Vice Speaker, Springfield

Past Presidents

Gary A. Dyer, St. Joseph
H. Peter Ekern, Mexico
Walter A. German, Springfield
Walter T. Gunn, St. Louis
Andrew McCanse, N. Kansas City
Howard J. McAlhany, Springfield
John N. Martin, St. Joseph
E. A. Stricker, Rolla

Deans of Medical Schools

William A. Peck, St. Louis (Washington University School of Medicine)
Lester R. Bryant, Columbia (Missouri University School of Medicine)

MSMA President Dorothy Reister, M.D., gave the invocation. Newton White, M.D., Chairman of the Committe on Credentials, reported that seven officers, 28 councilors, and 80 delegates were present. The minutes from the 133rd Annual Meeting were approved as published in the July 1991 issue of *Missouri Medicine.*

Speaker Ryall, announced the members of various reference committees: Reference Committee A - Carl Myers, (Chairman), James A. Diestelhorst, Mark R. Feldman, William Turner and Robert Swanson; Reference Committee B - Robert L. Zahn (Chairman), Octavio R. Chirino, Michael Zylka, and Daniel Buerger (Medical Student); Reference Committee C - Nathaniel Murdock (Chairman), Ann Peick, Ronald J. Sharp, Norman R. Wall and Alan Taege.

Dr. Reister addressed the House and her remarks appear on page 407 of this issue. Next Speaker JoEllyn Ryall invited Dr. Carol Williams, President-Elect to give her remarks. Dr. Ryall then invited MSMA Auxiliary President Mary Hunkeler to address the House. Mrs. Hunkeler's remarks appear on page 411 of this issue.

Following her remarks, Mrs. Hunkeler asked Dr. Reister to assist her in distributing the AMA-ERF checks to Missouri's four medical schools. Dr. Fred DeFeo accepted the checks for the University of Missouri-Kansas City School of Medicine. UMKC received $4,345 in designated contributions and $4,275 in undesignated contributions. Representing the University of Missouri-Columbia School of Medicine, Dr. Hugh E. Stephenson, Jr., accepted $9,166 in designated contributions and $5,000 in undesignated contributions. Dr. Manuel Comas, of the St. Louis University School of Medicine, accepted $11,561 in designated contributions and $12,642 in undesignated contributions. On behalf of Washington University School of Medicine, Dr. William Peck accepted $7,540 in designated contributions and $5,341 in undesignated contributions.

Vice-Speaker, James B. Wolfe, M.D., invited Dr. Reister to present the Presidential Citation to Dr. George Mandler. Dr. Mandler was a young Jewish doctor in Czechoslovakia in the 1930s. Dr. Mandler survived detainment in a concentration camp in eastern Czechoslovakia. After the camp was liberated Dr. Mandler and his wife, Erika, which he met in the camp, eventually made it to the United States in 1949. Dr. Mandler came to Missouri at the request of Don Dowell, M.D., in Chillicothe. He is a very well liked by his colleagues in the Grand River Medical Society.

Dr. Reister presented a plaque in recognition and appreciation to Don Sessions, M.D. Dr. Sessions began as editor of *Missouri Medicine* in 1988 and recently stepped down from the position.

Dr. Wolfe then announced that the Reports of Officers, Committees and Commissions were referred as shown in the Delegate's Handbook. No supplemental reports were shown. Dr. William C. Shell, Chairman of the Board of Directors of the Missouri Patient Care Review Foundation (MPCRF), presented the report of the MPCRF and introduced Dr. Tom Zink, the new Medical Director. Following this report, Melvin Kasten, M.D., presented a report on the Missouri Medical PAC during which he reported membership of 1,374 members, 86 sustaining and 31 that are members of SuperPAC. Next Howard McAlhaney, M.D., presented a report on MOMEDICO. During his report, Dr. McAlhaney presented a check in the amount of $6,500 to Dr. Reister in support of the Physicians Health Program (PHP). Dr. Reister also called for thanks from the House for Risk Control Mutual and Dr. Ray Christy for contributing to these programs.

Vice Speaker Wolfe then called on Mr. Charles Stokes to give the Missouri Department of Health report.

Dr. Wolfe announced that the Supplemental Report of the Council will be referred to Reference Committee B.

Dr. Reister announced the appointments for the 1992 Committee on Nominations whose members are chosen from each of the Councilor Districts:

First District:	Ben Moranville, St. Joseph
Second District:	Ed Plowman, Hannibal
Third District:	Jonathan Dehner, St. Louis
Fourth District:	Jeff Copeland, St. Charles
Fifth District:	Joe Corrado, Mexico
Sixth District:	Jerry Meyer, Concordia

Sevent District: Larry Rues, Chairman, Kansas City
Eighth District: Walter German, Springfield
Ninth District: Robert Jones, West Plains
Tenth District: Tom Sparkman, Cape Girardeau
Resident Physician Section: Maria Evans, Columbia
Student Councilor District: Lee Fox, St. Louis
Hospital Med. Staff Section: Jim Redington, St.Louis

Vice-Speaker Wolfe then asked the members of the House to all stand in silence in memory of the 60 members who have died this year.

Speaker Ryall called attention to the information distributed on the status of MSMA House of Delegates resolutions from the MSMA Annual Meeting in 1991 and to 16 late resolutions requiring two-thirds majority to become official business. The resolutions were accepted by the House. Speaker Ryall informed the House in which committee each added resolution would be discussed.

After brief announcements the First Session of the MSMA House of Delegates was adjourned.

SECOND SESSION

The Second Session of the House of Delegates was called to order by Speaker Ryall at 4:00 p.m., Friday, April 10, 1992.

Dr. Ryall announced that all 56 resolutions were adopted for discussion. The time limit of two minutes was set for each speaker.

Dr. Newton White gave the Credentials Committee report, stating that nine officers, 31 councilors, and 194 delegates were present.

Dr. Reister then presented the 1992 Legislative Awards to several members of the Missouri General Assembly. Receiving special plaques of appreciation for their service on behalf of medicine were: Senator Ed Dirck (24th District), Senator Irene Treppler (1st District), Representative Joe Ortwerth (18th District), and Representative Quincy Troupe (62nd District).

Following these presentations, Larry Rues, M.D., presented the report of the Nominating Committee that proposed the following slate of officers for 1992-1993:

President-Elect: Melvin C. Kasten, Cape Girardeau
Vice-President: Harry Cole, St. Louis
Michael Bukstein, Hannibal
Richardson K. Noback, Kansas City
Speaker of the House: James B. Wolfe, Jr., Springfield
Vice-Speaker of the House: Fred DeFeo, Kansas City
AMA Delegates: George Bohigian, St. Louis
Walter A. German, Springfield
Robert R. MacDonald, Jr., St. Louis
Hugh E. Stephenson, Columbia
AMA Alternate Delegates: Robert Gibbons, Kansas City
William Huffaker, St. Louis
Jack Kayes, St. Louis
Carl Strauss, Kansas City
Jo-Ellyn Ryall, St. Louis
Russell Burton, Columbia

Dr. Reister announced the appointments of Dr. Carl Strauss, chairman, Dr. John Renner, Dr. Jim Rogers, and Dr. Ann Peick to the Ombudsman Committee.

Speaker Ryall then moved the House business to the reports of the Reference Committees. Reference Committee Reports were heard in the order of Committee C then Committee A. Due to time limitations, Reference Committee B was moved to the Third Session.

Please note that House Actions on all resolutions appear in the section "Resolutions" on page 414 of this issue.

REFERENCE COMMITTEE C

Nathaniel Murdock, M.D., presented the report of Reference Committee C. The following items were placed on the consent calendar.

Report of Commission on Continuing Education and Health Manpower Report of the Physicians Health Committee
Report of the Commission on Medical Economics
Third Party Medicine and Governmental Relations
Report of MSMA Professional Liability and Tort Reform Blue Ribbon Committee

The Consent Calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Resolution 1	MSMA Position on Patient Health Care Accountability
Resolution 5	Optional Disability Insurance Coverage for HIV Seropositive Conversion
Resolution 11	MSMA Position on HCFA Rule That Only Physicians or Staff May Complete Certificates of Medical Necessity for Medicare Oxygen
Resolution 13	MSMA Position on Removal and/or Repair of Non-Oral Facial Lesions by Oral Surgeons
Resolution 14	MSMA Position on Medicare's Unfair Payment Practices for Starting Physicians Society

Resolution 37	Medicare Fee Discrimination Against New Physicians
Resolution 15	MSMA oppose the use of Diagnosis Related Groups as a system of reimbursement by Medicare for physician payment
Resolution 18	MSMA Position on Laboratory Rules Proposed by HCFA As result of CLIA
Resolution 20	MSMA Position on Constitutionality of Limiting Charges
Resolution 40	Insurance Costs as Part of Healthcare Costs
Resolution 46	Increased Physician Participation in Missouri PRO
Resolution 50	Physician Collective Bargaining
Resolution 51	Observation Status
Resolution 52	Pediatric Care in Missouri
Resolution 54	Further Government Intervention

REFERENCE COMMITTEE A

Carl M. Myers, M.D., presented the report of Reference Committee A. The following items were placed on the consent calendar:

Resolution 6	Health Access America Model Legislation
Resolution 16	Labeling of Prescription Samples
Resolution 17	Education on Use of Controlled Drugs
Resolution 19	MSMA Position on Use of Amphetamines and Amphetamine-like drugs for Treatment of Obesity
Resolution 43	Identity of Accuser
Resolution 47	Reporting of Filed Malpractice Suits Against Physicians to the State Board of Registration for the Healing Arts

The Consent Calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Resolution 7	Schedule Five Cough and Cold Medicine
Resolution 8	MSMA Position on Safety Devices to Prevent Tractor/Trailer Underride Accidents in Missouri
Resolution 9	MSMA Position on Giving of Expert Medical Testimony as Part of Medical Practice
Resolution 22	Qualifications of the Expert Medical Witnesses
Resolution 10	MSMA Position on Statute of Limitations for Physician Discipline by the State Board
Resolution 21	Proposals by the Missouri Coalition for Equitable Workers' Compensation
Resolution 23	Inappropriate Use of DEA Numbers
Resolution 24	Drivers' Liability Insurance
Resolution 27	Amendments and Revisions of Current MSMA Policy No. 2, Board of Healing Arts
Resolution 32	MSMA Support of a Data Collection Bill
Resolution 34	Premarital Testing for Certain Dieases
Resolution 39	Obstetrical Care in Missouri
Resolution 41	Sterilization of Patients
Resolution 44	Board of Healing Arts Hearings
Resolution 45	Initiative for Improved Indigent Primary Care Coverage
Resolution 48	Survey on Fairness of Present Tort Liability System
Resolution 55	Third-Party Payer Billing Practices

Following the report, it was moved that one item of business in Reference Committee B be heard. Robert L. Zahn, M.D., presented Resolution No. 49, Medical Student Section Governance.

The rest of the report by Reference Committee B was delayed to the next day. The Second Session of the MSMA House of Delegates was adjourned.

THIRD SESSION

The Third Session of the MSMA House of Delegates was called to order by Speaker Ryall at 7:30 a.m., Sunday, April 12, 1992. Dr. Newton White presented the Report of the Committee on Credentials, stating that nine officers, 32 councilors, and 213 delegates were present. This represented a quorum and the report was adopted.

The first item on the agenda was the election of the officers. These individuals were presented by the Nominating Committee during the Second Session (See page 397 for complete list). Following the election of Mel Kasten, M.D., President-Elect, he addressed the House during which he presented a plaque to his wife, State Representative Mary Kasten, for her support of medicine. Those listed on the nominated slate were elected.

Following completion of elections Dr. Williams presented Wilma Sperry, MSMA Staff, with a resolution honoring her for 25 years of dedication and service to the association.

Meredith Payne, M.D., announced the Missouri

Association of Plastic Surgeons and the St. Louis Area Plastic Surgeons Presentation Award winners.

First Place: Dr. Hauw Han, St. Louis University - *Lateral Forefoot Flap*
Dr. Thomas O'Daniel, Washington University - *Somatotopic Organization of the Facial Nerve*

Honorable Mention: Dr. R. Nath, Washington University - *Expression of Transforming Growth Factor-Beta in Fetal and Adult Wound Healing in Rabbits*

Special Mention: Russ Griffith, student, Washington University - *Experimental Study of the Use of Silicone Microprostheses (neurocuff Fasttube) in Peripheral Nerve Repair*

REFERENCE COMMITTEE B

Robert L. Zahn, M.D., chairman of Reference Committee B, announced that his committee, including the statement made by Norman P. Knowlton, III, M.D., that total membership in the association is up while active membership dropped during 1991 (See Report of the Secretary, page 302), had placed the following items on the Consent Calander:

Report of the President
Report of the MSMA Auxiliary
Report of the Committee on Legislative Affairs
Report of the Secretary
Report of the Treasurer and MSMA Financial Statement
Report of the Ethical and Judicial Affairs Council
Report of the Executive Vice President
Council Minutes
Report of the Missouri State Medical Foundation - MSMF Financial Statement
Report of the Commission on Interspecialty Medicine
Report of the Commission on Public Affairs
Report of the Committee on Publications
Report of the Ad Hoc Committee on "Sunsetting"

The Consent Calendar was adopted by the House. The Committee then made recommendations on the following resolutions:

Resolution 2	STATS Being Taught in Junior and Senior High Schools
Resolution 3	MSMA Public Affairs Commission to Increase its Public Service Announcements and Brochures Available to Citizens of Missouri
Resolution 4	MSMA Immediate Past President to Serve on Executive Committee
Resolution 12	MSMA Position on a National Practitioner Data Bank for Attorneys
Resolution 25	Death and Dying
Resolution 26	Amendments and Revisions of the Current MSMA policy No. 9 - Drugs, Generic Prescribing
Resolution 28	Amendments and Revisions of Current MSMA Policy No. 50 - Physician, Right to Choose
Resolution 29	Theraputic Substitutions by Classes of Drugs
Resolution 30	Review Panel for Candidates for Appointive Office
Resolution 33	Policy on Contributions to MSMA Members' Campaigns for AMA Elective Office
Resolution 35	Ear Piercing Guidelines
Resolution 36	Young Physicians Committee
Resolution 38	Increasing the Number of Primary Care Physicians Through Student Loan Deferment
Resolution 49	Medical Student Section Governance
Resolution 53	Sponsorship of Scientific Papers

Norman P. Knowlton, III, M.D., then gave the Report of the Election of Councilors and Vice Councilors. These elections were held in the respective district caucuses:

First District

Stephen Vilmer, Councilor
Robert Schaaf, Vice Councilor

Third District

Daniel O'Sullivan, Councilor
Fred Peterson, Councilor
Newton White, Vice Councilor

Fifth District

Jerry Murrell, Councilor
Jerry Kennett, Councilor
Robert Wankum, Vice Councilor

Seventh District

William Dorzab, Councilor
Robert Gibbons, Councilor
Linda Dorzab, Vice Councilor

Eighth District

Duane Hellam, Councilor

Ninth District

Dave Barbe, Councilor
Thomas Stubbs, Vice Councilor

Tenth Councilor District

Bill Shell, Councilor
Mark Kasten, Vice Councilor

Medical Student Section

P.J. Keizer, Councilor
Chris Hinrichs, Vice Councilor

Resident Physician Section

Karen Zanol, Councilor
Robert Swanson, Vice Councilor

Hospital Medical Staff Section

Charles Barbee, Councilor
Luis Anglo, Vice Councilor

Young Physicians Section Delegates to the AMA

Evan Crandall, St. Louis
Phillip Hornbostel, Sedalia

Young Physicians Alternate Delegates to the AMA

Rebecca Lueckenhoff, Jefferson City
Sandra Visner, Kansas City

After those elected had taken an oath of office, Dr. Carol Williams announced her appointments of Committees and Commissions chairmen *(Please note that a complete list of all MSMA standing Committees and Commissions will appear in the August Directory issue of Missouri Medicine).*

Committee on Constitution and Bylaws

Melvin L. Glazer, St. Louis

Committee on Legislative Affairs

H. Jerry Murrell, Columbia

Physicians Health Committee

Thomas R. Anderson, Columbia

Committee on Planning

Stephen C. McCray, Gladstone

Commission on Continuing Education and Health Manpower

Michael W. Vannier, St. Louis

Commission on Medical Economics, Third Party Medicine and Governmental Relations

James T. Rogers, Springfield

Commission on Medical-Legal Affairs

Joseph A. Corrado, Mexico

Commission on Public Affairs

Daniel B. Brennan, St. Louis

Commission on Interspecialty Medicine

Stephen Slocum, St. Louis

Publications Committee

J. Regan Thomas, St. Louis

Judicial Council

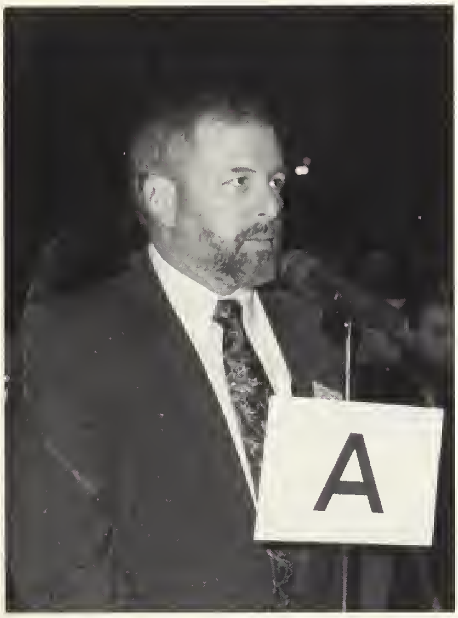
Ronald A. Youmans, Kansas City

Vice-Speaker Wolfe announced that the 135th Annual Convention will be held March 31 to April 4, 1993 at Tan-Tar-A, Lake of the Ozarks. The 136th Annual Convention will be held April 6 to 10, 1994 at the Crown Center Hotel in Kansas City. The 137th Annual Convention will be held March 29 to April 2, 1995 at the Adams Mark Hotel. The 138th, in 1996, will be held at the Lake of the Ozarks, as voted last year. An invitation was extended to hold the 1997 Annual Convention in Kansas City.

Following announcements, Vice-Speaker Wolfe adjourned the House of Delegates on April 12, 1992.

Editor's Note: Complete minutes for the 134th Annual Convention are on file at the MSMA Headquarters, 113 Madison, Jefferson City, MO. Any MSMA member interested in viewing the complete report may do so at the MSMA Office.

FROM REFERENCE COMMITTEES TO THE HOUSE OF DELEGATES, MEMBERS HAD MUCH TO DISCUSS



Mark Kasten, M.D., 10th District delegate, brings attention to an added resolve during the Second Session of the House.

Russell Burton, student, speaks with members of Reference Committee B; from left to right, Dan Burger, student, Chairman Robert Zahn, M.D., and Michael Zylka, M.D.

MISSOURI STATE MEDICAL ASSOCIATION
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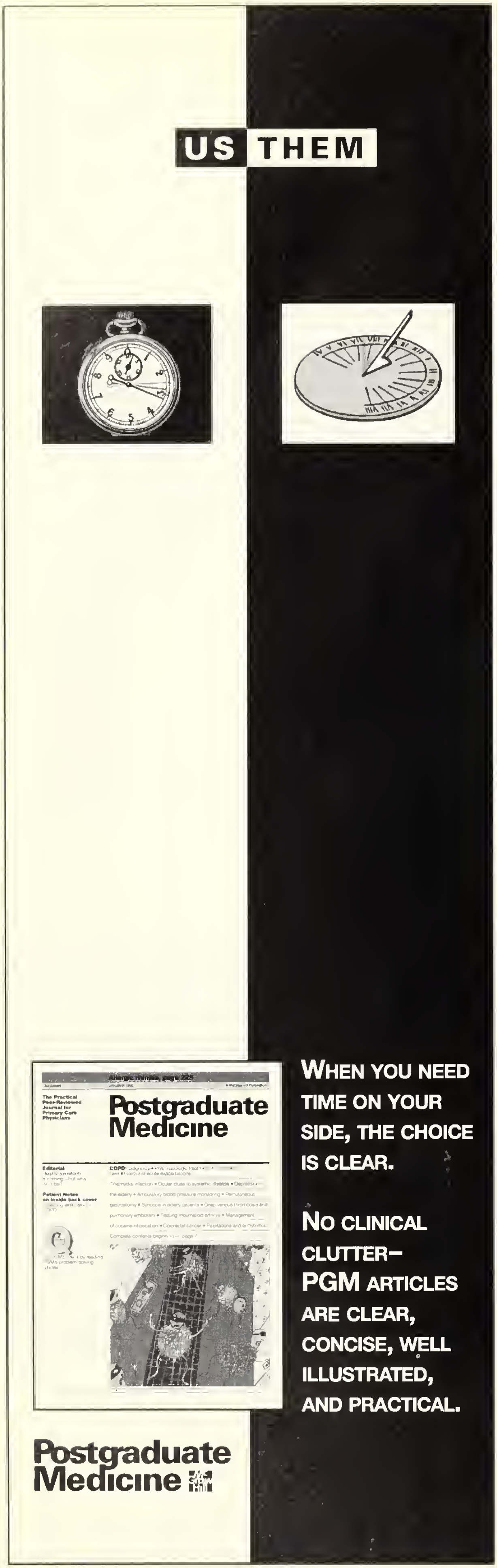
There were 538 members present at the convention, an increase from previous years. In the House of Delegates, 228 Delegates worked hard to hear and vote upon all 56 resolutions, which included 16 resolutions added at the convention.



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SEEKING MEDICINE'S GOOD

by
Carol Williams, M.D.

I am honored that you have chosen me to lead the Missouri State Medical Association for the next year. I commit myself to serving you in this job by seeking medicine's good as best I can discern it. You gave me, as a symbol of my office, a gavel - a skull attatched to a humerus - a head bone connected to an arm bone. It has always struck me as a macabre symbol - it's almost a poison symbol; it also reminds me of those bleached bones around the poisonous waterholes of the western deserts. But maybe that's the vision some people have of the House of Medicine - that we are a poisonous bunch or else a pile of disarticulated dead bones. Maybe what's abroad in the land is the notion that physicians collectively are not a profession with the completeness that use of the word implies, but are a business to be bought or sold, merged or dismembered at the whim of bureaucracies, insurance companies, Congress and legislatures, lawyers and the public.

Webster's Third International Dictionary defines business as: "a usually commercial or mercantile activity, customarily engaged in as a means of livelihood, and typically involving some independence of judgement and power of decision, and sometimes contrasted with the arts or professions, or sport, or other activity considered less practical, serious, respectable, or mundane." Synonyms are: occupation, position, trade, line.

Profession is not a synonym for business. Webster defines profession as: "a calling requiring specialized knowledge and often long and intensive preparation, including instruction in skills and methods as well as in the scientific, historical or scholarly principles underlying such skills and methods, maintaining by force of organization or concerned opinion, high standards of achievement and conduct and committing its members to continued study and to a kind of work, which has for its prime purpose, the rendering of a public service." There are no synonyms for profession. Yesterday the Association honored Dr. Damler, a physician who through his long years of practice exemplified the very embodiment of professionalism in medicine.

I want to focus tonight on the purpose for which physicians hold themselves out to the general public: the rendering of a public. We are in an era where the provision of medical care by physicians is severly impeded by barriers to access - primarily economic barriers - but also barriers created by restricted numbers of primary care physicians.

When my father was in the general practice of medicine in the 1930s and 1940s, it was a world of house calls, hospital rounds, delivering babies, answering the phone, and being away from one's family for many long hours. Sometimes he was paid and sometimes he wasn't, but he understood his job as that of offering his service to the public - directly to the public, not through any intermediaries; the contract was, and still is according to law, a direct one between patient and physician. Access was reasonably uncomplicated. But today patients contract with third party payors to obtain medical services. The cost of medical care has mushroomed because of increasingly sophisticated technology and methods of care, as well as exploding malpractice settlements and the administrative cost of third party payors. The country is discovering that it cannot afford the cost of medical services, and at a time when there are record numbers of physicians in the United States, large segments of our population can no longer have access to the medical care available. Thus the uninsured poor, the unemployed, the working poor, those with pre-existing conditions, the elderly poor - they all have great difficulty finding health care, particularly if they need sophisticated tests, high-priced medication or hospitalization. Public funds for immunization programs, public health nurses, tuberculosis and other communicable disease tracking programs have been siphoned away or not appropriated, with the result that greater public funds are being spent on the acute and chronic illnesses that could have been prevented by those programs. Furthermore, rural physicians and family practioners have stopped doing obstetrics because of high malpractice premiums, so pregnant patients in rural Missouri are travelling long distances for prenatal care or are not getting such care at all.

Another hindrance to access to health care is the dwindling supply of primary care physicians - the family practitioners, the pediatricians, the internists. The recent trend in the percentage of residency slots filled in primary care specialities is downward. This is unlikely to be reversed in the next decade, because medical students are graduating with debt loads that approach the size of a mortgage on a first home, and are not entering those specialities that are at the low end of the income scale, the primary care specialities. Studies of entering freshmen medical students have shown that the majority of students now regard medicine as a good way to the good life -- not as in former years -- to a life of service. They regard medicine as a business to be profited from, not as a profession. The supply of physicians needed for delivering basic medical care is drying up.

Solutions to these problems of access are not going to be easy. For several years the country has increasingly intense in its demand for improved access to health care. I believe the climate is ripe for the several players - medicine, insurance companies, hospitals, legislators, and public - to hammer out workable solutions to the problems of access. We should gather together representatives of the various groups concerned with these issues, lock them in a room, and let them out only when they have developed a workable plan which will provide access to care for all segments of the population, preserve the doctor-patient relationship, and promote patient responsibility for their own health. I envision such a plan as flexible and containing individual elements which will meet the basic needs of each segment of the population in cost-effective ways and which will contain both public and private components. The AMA's Health Access American is an excellent start in this direction, as is the Health Care Forum's proposed legislation recently discussed in the Missouri Legislature.

Physicians have an obligation to their patients to educate them about the illnesses to which they are subject. By strengthening our commitment to educating the public about life-style choices which drain health care resources away from preventive programs, we hope to help the public change behavior which leads to illness needing acute medical care. MSMA Auxiliary has done an excellent job of public education with its Shaken Baby and Infant Car Seat Programs. In the coming year we will encourage them to continue their focus on public education by expanding into some other areas of concern.

To address the problem of diminished primary care physicians, I propose that MSMA work with the medical schools on ways of encouraging graduating medical students to choose primary care specialties as their fields of practice. In collaboration with medical schools, public and community health centers MSMA should help develop pilot programs which will explore ways of expanding the primary care physician. We should become more sensitive to the needs of current primary care practitioners by providing more intraprofessional support for them.

We will continue our liaison with the Department of Health and continue to communicate our concerns about immunization programs and tracking programs which have been severely curtailed because of funding cuts. Finally, we encourage physicians to continue their pro bono work, which many are already performing in their own offices, in hospitals, and in clinics around the state.

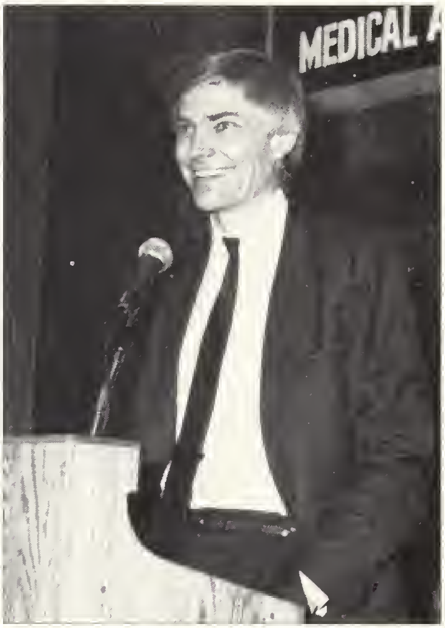
The head bone connected to the arm bone - no - the House of Medicine really is a whole skeleton forming the matrix upon which the health care system rests and from which it derives its ability to function. Scavengers such as the malpractice insurance crisis and Medicare regulations have picked and scattered the bones, but let's tie them back together and get on with our work. You remember the anatomy: the foot bone connected to the ankle bone, the ankle bone connected to the leg bone, the leg bone connected to the thigh bone...

This year I want to hear the clacking of those bones as they come together. I want to hear the lub-dub of the heart beat, the in and out of respiration (without rales, please), the enfleshing of the bones with muscles, skin, hair, ears, eyes, mouth. I believe our country is looking to us for help in solving the health care crisis. I also believe we have the ability and the commitment to be major players in those solutions. ❐

SMILE!

ASSOCIATIO

President-Elect, Melvin Kasten, M.D., brought his wife, Mary, before the Third Session of the House of Delegates to present her with a plaque for all that she has done for medicine as a State Representative.



Peter Huber, columnist and lawyer, presented his topic, *Junk Science & Quak Medicine in the Courtroom.*

From left to right: 1991-92 MSMA President, Dorothy Reister, 1992-93 President-Elect and MSMA PAC Chairman, Melvin Kasten, 1991-92 MSMA Auxiliary President Mary Hunkeler, Auxiliary Long Range Planning Chairman, Sandra Mitchell, MSMA Auxiliary MPAC Chairman, Jan Meyer, and Vince Shoemehl, St. Louis Mayor and candidate for governor, who served as guest-speaker at the PAC Breakfast.

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United We Stand

Dorothy R. Reister, M.D.

Once again it is my privilege to stand before this group as your president. I have had quite a year. I want to thank everyone connected with MSMA for their thoughtfulness, their flowers, plants, cards, telephone calls. There is no way I can express my deep, deep gratitude and love for the members of this organization. But, again I will say "thank you".

This is a moment to look backward and to look forward. The problems confronting our profession are increasing. My hope has been and continues to be that, by cooperating and truly working together, we can come to some solutions.

During the past year, we have had meetings with several of the organizations that have problems similar to the ones being faced by MSMA, particularly the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS), the Missouri Bar Association, the Missouri Hospital Association and the AARP. Our combined anxiety creates a coalescence of concerned people.

We had pressed for several months to meet with the Board of Healing Arts. During my travels throughout the state, the largest number of complaints I heard from physicians concerned the Board of Healing Arts. Our associates in MAOPS report many of the same problems.

As you are aware, the state legislature mandated the CME requirement for physicians to retain their licenses. The lawmakers left it to the Board of Healing Arts to define how this requirement would be satisfied. The BOHA decides the number of hours needed and how long you have to get those hours.

This issue has been terribly confusing to a lot of people. For example, where do we stand with the Board's decision to ignore the physician's recognition award as proof of meeting the CME requirement? Well, we are continuing to address such issues with the Board.

On February 20th, 1992, in St. Louis, representatives of our association, met with MAOPS, and the Board of Healing Arts, with execs from each of those three organizations. This was a concentrated meeting with discussion and interchange. There was no belligerence as we described some of our problems and we agreed there were some we couldn't begin to tackle in one day. This meeting happened in part because of a bill (SB 849) that was introduced in the legislature. This bill would have granted greater due process to physicians being investigated by the Board of Healing Arts. The Board felt that they couldn't live with such a measure and wanted to improve communications rather than have the issue resolved by legislative action.

Because of the give and take by both sides, we had hopes that this initial meeting would become at least quarterly meetings and that we could develop effective legislation that could be introduced and supported by all of us. As you know, the President of the Board resigned shortly after that meeting, but, the current president has told me he wants to continue this type of dialogue.

If we can have a more unified approach to upgrading physician review and people can see that we are not trying to protect bad doctors, then we have a chance of working toward meaningful changes. When the various medical groups try to work separately, people outside our groups may see us as being self-serving. Nothing could be further from the truth, we do not want to protect bad doctors. But we do want to protect the vast majority of good doctors with proper due process procedures.

Also, there is the issue of the retired physician who, as it stands now, is no longer licensed and according to our bylaws not a member. We can change our by-laws. But isn't it unfortunate that people who have given many years of dedicated service to care for patients (and who are citizens of the State of Missouri, too) are made to feel like second- or third-class citizens. That's not right. These doctors should be allowed to retire with respect and dignity and the thanks of everyone of us.

With time we will resolve this in some way, but we still have to deal with the question of how to handle licensure for retired doctors who want to practice part-time or to do volunteer work. This is a sticky issue because it involves maintaining quality of care and this is a concern for all of us. Along with retirement and surrendering your license, however, there clearly needs to be more specific guidelines as to what a retired physician can and cannot do. This is not spelled out well enough.

One more item from that meeting. The Board's representative said that of the 1400 cases reviewed last year, 80 percent were settled with no action. To me, that means there's been inadequate education about the review of minor incidents and problems. Months of investigation and meetings should not end with, "We settled the matter with no action."

If physicians need additional training to avoid review of their cases, let's do it. The Board says they are not in the education business, but, in the long run, it should help by getting their caseload down to a reasonable level.

There are some bad doctors out there. The Board has shared case reports with us, after blanking out the physicians' names, and they have their problems. They have a problem in getting truthful responses from some doctors and we immediately bring our lawyers into the fray. This is too bad because there to me seems to be a lot of things that could be settled with a letter, or a face-to-face meeting one time, without attorneys present.

Even if we are scared, it's time to act like professionals dealing with other professionals. We are not recalcitrant children. We are members of a fine profession and we must learn to say, "I'm Dorothy Reister. I've got a problem and this is what they're doing to me."

And, in the past year we have started the Medical Legal Seminar, first held in Columbia last September, between the Missouri Trial Lawyers Association, the Missouri Bar and MSMA. This has proven to be one of our best good coalitions. Doreen Dodson, the Bar Association president, however, made it very clear that the Trial Lawyers Association has their own agenda and they're the ones that meet us in the courtroom.

The second annual seminar, a one-day meeting, will be held September 12 in Columbia to address ethical issues. You remember that adoption of the living will and durable power of attorney legislation happened in Missouri because we worked with the legal profession and used their legal leadership to help make it happen. We hope to gain their support in other health care issues as well. And, there are many other issues confronting us in the months and years ahead and we'll need all of the support we can find.

We are bombarded with criticism about the rising costs of health care. We are a part of the problem because we are the ones who make the decisions about tests, hospitalization, and treatment. We have a responsibility to be aware of health care costs associated with our decisions. We must avoid unnecessary surgery, reordering tests too frequently, or routinely calling patients in for office visits that may not be necessary. We have a responsibility to look closely at those costs for which we are responsible.

And, we have a responsibility to talk about, not make, decisions regarding alternative-care for patients. We must take part in the debate or risk having no voice in the outcome of public policy.

The courts in Florida, for example, decided recently that the parents of a encephalic newborn could not donate that baby's organs for transplanting to other babies before "death" occurred. The only organs that could be transplanted were the corneas. It seemed to me that the parents were trying to salvage what blessings they could from a tragic situation. The loss of vital, healthy organs was a waste for a number of children and their parents who wait for needed organs. What do physicians have to say about "life" and "death" issues?

Doctors consider having a patient die to be something of a defeat. We must revamp our thinking because for some of our terminal patients dying is a blessing. We need to help each patient, or their family members in some cases, work through the question of what they really want done near end of life to prolong dying. This will require a great deal of compassion. We will encounter adult children who will feel bad about neglecting their elderly parent and who ask that life be extended for a comatose woman who is on life support. It's hard to let go of a loved one even in the best of circumstances. Approaching the question early on, when the patient can express personal wishes, is the best course of action. Do you agree? What living will or durable power of attorney decisions have you made? What kind of example would you be to your patients?

We are concerned with living and healing. But we also know that there is the letting go and being able to do this with compassion, with consideration, and, hopefully, with time to have discussed it before. If we can do this, we can do a great favor for our patients through their illness.

We must help patients face these decisions at both ends of the life cycle. Should we, for example, devote more medical resources to save 500-gram preemies, as opposed to someone older. We are not certain about what will be the outcome of these babies. Some, who were one-pound preemies, at age eight are the brightest, smartest children in their classes. We see just the reverse situation, too. Should we advocate some type of rationing of care? And, what do we say about the de facto rationing of care that occurs because insurance companies pay for some treatment but not for others. Tough decisions await us as members of a profession and as individual professionals.

We see where our economy is at financially, the constraints being applied by government agencies, and we know doctors are going to experience some decreases or limits in income. Are we willing to bite the bullet while other professionals are allowed to charge market prices for their services? I recently heard of a young physician who admits that he went into his specialty, not because he particularly was interested in that field, but because it would provide him the best livelihood. I was appalled. I think I was appalled that he was cynical enough to admit it in public. But, if it's wealth that motivates young people to consider a medical career, that's changing and there will need to be other incentives. Nowadays growing wealthy as a doctor isn't as apt to happen.

Government intervention into medicine is a concern of mine. Physicians need to be involved in the legislative process. You can be a "key contact" with your state legislator. You can be involved in a PIP program. MSMA staff members are in Jefferson City to help guide you in these efforts. We can't afford to remain silent. We have to speak. We have to educate our legislators about health care issues.

And, we need to increase our MSMA membership. We must cut down whatever barriers may exist to recruiting new members.

So what's ahead of us? A blue ribbon committee is working on the risk management projects. We continue to consider our relationships with the Board of Healing Arts and with MAOPS.

We do need an increase in membership. We need an increase in cooperation. We need to be willing to be informed and to talk to the press, to the legislature, to our congressmen. We need a new legal definition of the practice of medicine.

But mainly, as I look to the future, I want to be able to stand before you and say, "I'm proud to be a physician." We should feel proud of ourselves and our profession. We work hard to keep our individual reputations spotless, admitting and learning from our honest mistakes when they occur, and we should take pride in being recognized as physicians.

I certainly am—as you have no doubt.

We have a long way to go. This is a long road. But we're on our way. SO CHARGE!

❑

Auxiliary Report

Continued from page 419

their time and resources to support our programs and activities.

The Auxiliary officers and State Board members in the back of the room have been remarkable this year giving their time, effort, and resources to help support the family of medicine and to improve the quality of life and health for everyone. They have made this year a success.

It has been my privilege to serve as president. I appreciate your kindnesses and support. And I will try my best to continue to work for the benefit of medicine in Missouri. Thank you for caring.

On behalf of the Medical Auxiliary, I wish you a successful and productive 134th Annual Convention.

❑

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The Auxiliary Works With You

Mary Hunkeler

Madam Speaker, Dr. Reister, Delegates, and Guests:

Thank you for the opportunity to report the accomplishments of the MSMA Auxiliary this past year.

As a member of the MSMA, you realize the importance of being an integral part of organized medicine in today's changing medical environment. With the intervention of government, business, the media, lawyers, and the lay public into your practice, the physician's role in our communities is no longer the same.

But the Auxiliary continues to work with you to help the public understand what we have always known, that the patients' needs are your top priority.

The Auxiliary is changing too. No longer are we primarily a social organization for physicians' spouses. We do sponsor social activities for fellowship and serve as a support group for physician spouses and family.

We are actively involved with and working for MSMA in the legislative arena, supporting health-related programs on drug abuse, teen pregnancy, shaken baby syndrome, AIDS education, fundraising for medical research and education and other related projects.

These projects combine to promote a positive image of physicians and medicine in your communities.

The attitude of caring for others to meet the health needs of our communities has always been a hallmark of the Auxiliary and the Medical Association.

Responding to community needs, many of our county auxiliaries give volunteer and financial support to ongoing programs as well as initiating their own projects dealing with issues such as substance abuse, teen pregnancy, family violence, and AIDS education.

At the local level more than $10,000 in funding for scholarships was distributed; more than 20 agencies received $23,000 in funding for local projects. And this is above and beyond what we have raised for AMA-ERF this year.

There are countless Auxiliary members who give tirelessly and without fanfare because they care about helping others. They are your spouses committed to making a difference.

One of the significant efforts of the Auxiliary this year was the completion of a two-year statewide public education program to prevent shaken baby syndrome injuries to infants and young children in Missouri. Its purpose is to prevent child deaths and serious injuries.

Auxiliary members promoted and distributed 875 posters, 1,500 fact sheets, and distributed more than 27,000 brochures to families, child-care providers, and health care professionals all over this state to educate people about the dangers of shaking young children and to provide alternative actions.

Brochures were placed in physician offices, pediatric clinics, baby-sitting classes, and given to new mothers in their baby packets. In coalition with the Missouri Chapter, National Committee for Prevention of Child Abuse and 16 other sponsoring groups, our two organizations worked together to bring this critical issue before the public.

The decline in membership in recent years remains a great concern. Less than one-half of physician spouses have joined the Medical Auxiliary. We need your help to recruit more members. Won't you please ask your spouse to join this coming year?

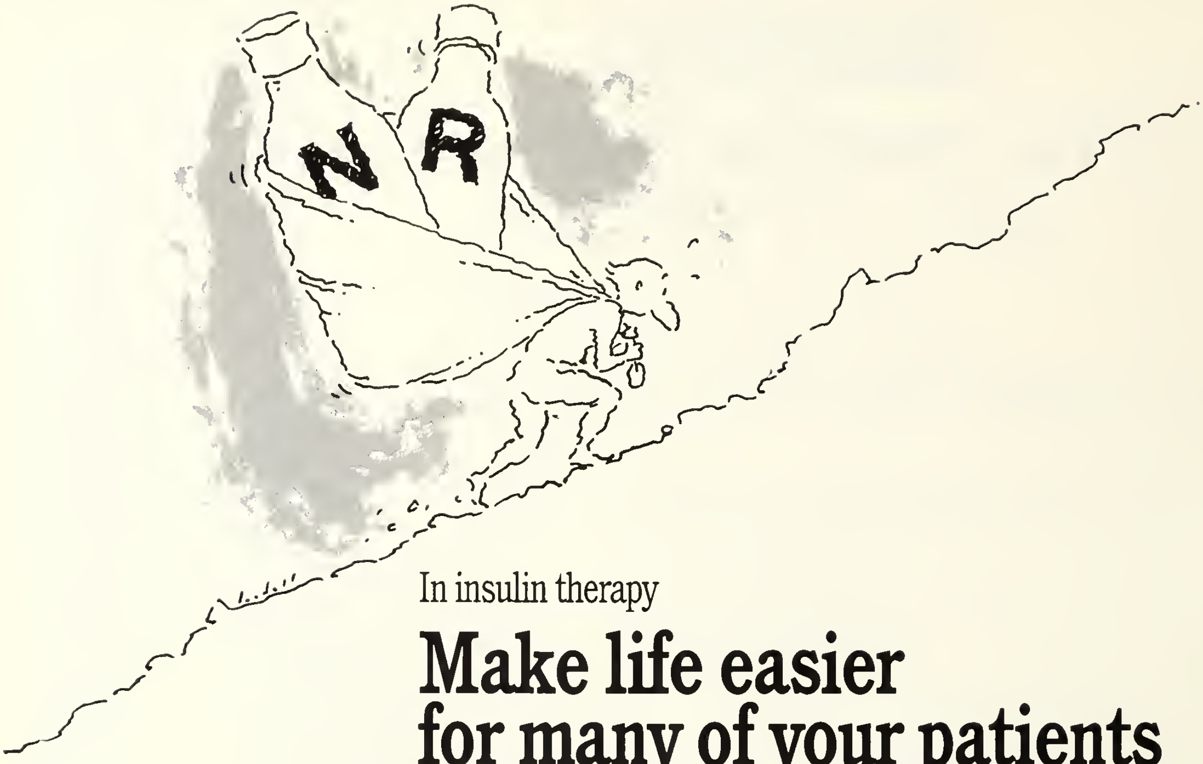
We're looking for a few good spouses who want hands-on volunteer experience. We want spouses who can only support us financially because of their busy careers or duties at home. There really is room here for each kind of member.

I am convinced people will join causes they feel are worthwhile even when they can't be personally involved. But we must be willing to adjust and to grow with the organization if it is to remain viable.

With the support of your officers and staff, I was privileged to learn about the issues and business of MSMA by attending the Council and Legislative Committees this year.

You need to know that the volunteer time away from family and patients, service to others, and just plain hard work that your association leadership gives on behalf of medicine is truly exemplary.

Continued on page 409



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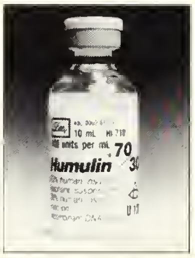

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Installation of Officers Ceremony

Continuing a tradition, the 134th annual convention closed with the swearing in of new officers. Dr. Norman P. Knowlton, III, MSMA secretary, conducted the ceremony.

Let's look at it this way ......

The annual convention provides many opportunities for physicians to talk informally about medical issues. Robert MacDonald, Jr., M.D., left, presents his views to Dr. Vernon Balster.

RESOLUTIONS

of the 134rd Missouri State Medical Association House of Delegates

Resolution 1

MSMA Position on Patient Health Care Accountability

RESOLVED, that the Missouri State Medical Association recognizes as one of the chief flaws in the health care system of the United States the lack of accountability of patients; and be further

RESOLVED, that the Missouri State Medical Association encourage government, at all levels, whenever possible, to incorporate incentives for recipients of health care to behave in ways not detrimental to their own health.

House Action: The above substitute resolution was adopted.

Resolution 2

STATS (Students Teaching AIDS to Students) Being Taught in Junior and Senior High Schools

RESOLVED, that the Missouri State Medical Association2 actively support and encourage the use of STATS (Students Teaching AIDS to Students) program and the Missouri AIDS Speakers Bureau in Missouri schools.

House Action: The above amended resolution was adopted.

Resolution 3

MSMA Public Affairs Commission to increase its public service announcements and brochures available to citizens of Missouri

Introduced by Richard Heimburger, M.D., and the Boone County Medical Society Board of Directors

RESOLVED, that the Missouri State Medical Association reaffirms the important concept of preventive health and medical care by urging the Public Affairs Commission to increase its public service announcements and brochures available to the citizens of Missouri regarding the increased cost of healthcare due to lack of attention to preventive measures such as alcohol related accidents, drug abuse, sexually transmitted diseases (including AIDS), child neglect and abuse, and smoking.

House Action: The above resolution was adopted.

Resolution 4

MSMA Immediate Past President to Serve on Executive Committee

RESOLVED, that the MSMA Bylaws be amended to provide that the Executive Committee shall include the MSMA's Immediate Past President.

House Action: The above resolution was adopted.

Resolution 5

Optional Disability Insurance Coverage for HIV Seropositive Conversion

Introduced by the Metropolitan Medical Society of Greater Kansas City

RESOLVED, that the AMA require all disability insurance carriers which provide coverage under its name, umbrella, endorsement, or control of any kind to include a policy option which defines conversion to HIV seropositivity as total disability,

RESOLVED, that the AMA strongly encourage all disability insurance carriers who write policies for physicians to include an HIV seroconversion option,

RESOLVED, that the AMA strongly encourage its component state and their component local societies to likewise require any company selling disability insurance under its control to include the HIV seroconversion option.

House Action: The above resolution was adopted.

Resolution 6

Health Access America Model Legislation

Introduced by the Boone County Medical Society Board of Directors

RESOLVED, that the AMA draft model legislation encompassing the concepts of Health Access America and distribute the model to state medical societies.

House Action: The above resolution was adopted.

Resolution 7

Schedule Five Cough and Cold Medicine

Introduced by Mark C. Kasten, M.D., and the Cape Girardeau County Area Medical Society

RESOLVED, that the Missouri State Medical Association recommend to the State Board of Healing Arts and the Drug Enforcement Agency that the regulations requiring physicians to keep detailed records of cough and cold medicines containing narcotics, which are dispensed in small quantities, be relaxed primarily because the law which is intended to protect the public and help provide quality medical care is, in fact, restricting the public's access to adequate and quality medical care.

House Action: The above resolution was referred to MSMA Council.

Resolution 8

MSMA Position on Safety Devices to Prevent Tractor/Trailer Under-ride Accidents in Missouri

Introduced by the Buchanan County Medical Society

RESOLVED, that the Missouri State Medical Association supports the passage of legislation requiring the modification of semi-trailers used in Missouri so as to prevent under-ride accidents involving passenger vehicles.

House Action: The above amended resolution was adopted.

Resolution 9

MSMA Position on Giving of Expert Medical Testimony as Part of Medical Practice

Introduced by the Buchanan County Medical Society

RESOLVED, that the position of the Missouri State Medical Association on the giving of expert medical testimony is to be considered part of the practice of medicine, and all licensed physicians, whether or not board certified, should be considered eligible to provide such testimony, so long as they do not exceed the limits of their training and experience in the subject area involved in the testimony.

RESOLVED, that this position be taken to the AMA with the intent of making the MSMA position the AMA position.

House Action: The above resolution was not adopted.

Resolution 10

MSMA Position on a Statute of Limitations for Physician Discipline by the State Board

Introduced by the Buchanan County Medical Society

RESOLVED, that the Missouri State Medical Association support the passage of legislation which would create a statute of limitations on the discipline of Missouri physicians by the Missouri Board of Registration for the Healing Arts.

House Action: The above amended resolution was adopted.

Resolution 11

MSMA Position on HCFA Rule That Only Physician or Staff May Complete Certificates of Medical Necessity for Medicare Oxygen

Introduced by the Buchanan County Medical Society

RESOLVED, that MSMA condemn the HCFA rule which prohibits suppliers from providing completed 'sample' forms to physicians for their use in completing Certificates of Medical Necessity for Medicare Oxygen, and be it further

RESOLVED, that MSMA take this issue to AMA with the intent of including AMA to resolve this problem through either legislative or legal avenues.

House Action: The above resolution was adopted.

Resolution 12

MSMA Position on a National Practitioner Data Bank for Attorneys

Introduced by the Buchanan County Medical Society

RESOLVED, that the position of the Missouri State Medical Association is that a National Practioner Data Bank is needed for all attorneys in the United States; and be it further

RESOLVED, that the position be taken to AMA with the intent of making the MSMA position the AMA position; and be it further

RESOLVED, that the MSMA make its position known to the U.S. Congressmen from Missouri.

House Action: The above resolution was not adopted.

Resolution 13

MSMA Position on Removal and/or Repair of Non-Oral Facial Lesions by Oral Surgeons

RESOLVED, that the MSMA request that the State Attorney General and the State Board of Registration for the Healing Arts take action to prohibit oral surgeons from removing and/or repairing non-oral facial lesions, and be it further

RESOLVED, that the MSMA research and develop a definition of the "Practice of Medicine".

House Action: The above amended resolution was adopted.

Resolution 14

MSMA Position on Medicare's Unfair Payment Practices for Starting Physicians

RESOLVED, that the position of the MSMA is that starting physicians should not be reimbursed by Medicare according to the lesser payment schedule, but that all physicians should be reimbursed equally for equal services, and be it further

RESOLVED, that the MSMA encourage its Congressional Delegation to co-sponsor HR 4507 and S 2362 which would repeal Medicare differentials for new physicians.

House Action: The above amended substitute resolution was adopted.

Resolution 15

MSMA Position on DRGs for Physician Payment

RESOLVED, that the Missouri State Medical Association is opposed to the use of Diagnostic Related Groups as a system of reimbursement by Medicare for physician payment.

House Action: The above amended substitute resolution was adopted.

Resolution 16

Labeling of Prescription Samples

Introduced by the Buchanan County Medical Society

RESOLVED, that MSMA cause to be introduced the necessary legislation to exempt samples from the Missouri law requiring that a label be affixed to all drugs dispensed by a physician, and to lobby its passage.

House Action: The above resolution was adopted.

Resolution 17

Education on Use of Controlled Drugs

Introduced by the Buchanan County Medical Society

RESOLVED, that the MSMA undertake to educate Missouri physicians about the fine points of the rules and regulations regarding controlled substances and how to be in compliance with them.

House Action: The above resolution was adopted.

Resolution 18

MSMA Position on Laboratory Rules Proposed by HCFA as Result of CLIA

Introduced by the Buchanan County Medical Society

RESOLVED, that the position of the MSMA is that the laboratory rules proposed by HCFA as a result of CLIA are much too restrictive, and should be immediately abandoned; and be it further

RESOLVED, that the MSMA make its position known to HCFA and the U.S. Congressmen from Missouri.

House Action: The above resolution was adopted.

Resolution 19

MSMA Position on use of Amphetamines and Amphetamine-like Drugs for Treatment of Obesity

Introduced by the Buchanan County Medical Society

RESOLVED, that the Missouri State Medical Association study the problem of the high rate of physician discipline for violations of the rules regarding the use of amphetamines and amphetamine-like drugs, seeking to identify causes of this problem, and to recommend solutions, working closely with the State Board of Registration for the Healing Arts of Missouri.

House Action: The above resolution was adopted.

Resolution 20

MSMA Position on Constitutionality of Limiting Charges

Introduced by the Buchanan County Medical Society

RESOLVED, that the Missouri State Medical Association urge AMA to challenge the constitutionality of the law which places limits on the amounts physicians may charge Medicare patients and take the issue to AMA with the intent of developing a plan of action to remove these limits.

RESOLVED, that this position be taken to AMA with the intent of making the MSMA position the AMA position; and be it further

RESOLVED, that the MSMA make its position known to the U.S. Congressmen from Missouri.

House Action: The above resolution was adopted.

Resolution 21

Proposals by the Missouri Coalition for Equitable Workers' Compensation

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that the MSMA opposes the proposed changes in the Workers' Compensation Law, designed to reduce the workers' legitimate benefits and deprive them from obtaining adequate treatment for their work-related injuries or illnesses, and be it further

RESOLVED, that the MSMA opposes any changes in the physicians' fee schedules as the complexity of treatment of work-related injuries and the amount of time spent to care for the patient, communicate with employers, insurers, therapists and lawyers is excessive, therefore many of the physicians currently engaged in treating these workers will be forced to sharply reduce or totally stop providing care to the workers leading to a limited access and unnecessary delays, and be it further

RESOLVED, that the MSMA organize a grass roots campaign by its members to inform the legislators, elected and appointed officials, union representatives and other interested parties of the potential harm these proposals will induce if adopted.

Resolution 22

Qualifications of the Expert Medical Witness

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that the Missouri State Medical Association endorses legislation to delineate the physician expert witness in that the witness shall -

1) have a current, valid, unrestricted license to practice medicine in the state in which he or she practices;

2) be fully trained in a specialty or a diplomate of a specialty board recognized by the American Board of Medical Specialties, and qualified by experience or demonstrated competence in the subject to the case. The specialty of that physician should be appropriate to the subject matter in the case;

3) be familiar with the clinical practice of the specialty or the subject matter of the case at the time of occurrence and should be actively involved in the clinical practice of the specialty or the subject matter of the case for three of the previous five years at the time of testimony;

4) affirm that less that twenty (20) percent of his/her professional activities involves service as an expert witness.

House Action: The above resolution was adopted.

Resolution 23

Inappropriate Use of DEA Numbers

RESOLVED, that the MSMA believes that the Drug Enforcement Agency should refrain from divulging a physician's DEA number unless there is a valid reason for doing so; and (2) believes that insurance companies and pharmaceutical companies should use a physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled subtances are not involved, and be it further

RESOLVED, that MSMA encourage physicians of the State to remove their certificates from public display, and be it further

RESOLVED, that the MSMA encourages the Insurance Commissioner of the State of Missouri to certify that the license number issued by the Missouri State Board of Registration for the Healing Arts is the only valid number to be used for physicians indentification in the State of Missouri.

House Action: The above substitute resolution was adopted.

Resolution 24

Driver's Liability Insurance

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that no driver's license be issued to anyone without definite proof and evidence of their liability insurance policy, and be it further

RESOLVED, that the MSMA Legislative Affairs Committee support and encourage the legislature to pursue strict enforcement of current law relating to automobile liability insurance.

House Action: The above resolution was not adopted.

Resolution 25

Death and Dying

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that a comprehensive and unified resource on death and dying be specifically developed through the Council on Scientific Affairs, Council on Judicial and Ethical Affairs, and any other appropriate council or committee of the American Medical Association, and be it further

RESOLVED, that this comprehensive and unified resource on death and dying include a definition of death, guidelines for withholding treatment, living wills, durable power of attorney, patient autonomy, medical-legal aspects of end-of-life care, and related discussion, and be it further

RESOLVED, that this resource be widely distributed to physicians throughout the nation.

House Action: The above amended resolution was adopted.

Resolution 26

Amendments and Revisions of the Current MSMA Policy No. 9 - Drugs, Generic Prescribing.

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that the MSMA is opposed to any interference into the practice of medicine by any governmental agency, third party payor or commercial dispensing organization through mandated generic substitution for physician prescriptions, and be it further

RESOLVED, that this resolution replace the current policy No. 9 in the current policy manual of the MSMA, and be it further

RESOLVED, that such policy be recommended to the AMA.

House Action: The above amended resolution was adopted.

Resolution 27

Amendments and Revisions of the Current MSMA Policy No. 2 - Board of Healing Arts

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that the MSMA continue to oppose any legislation that would dilute the licensing power of the State Board of Registration for the Healing Arts to license physicians of good moral and ethical character, and be it further

RESOLVED, that MSMA has great concern regarding the sometimes overzealous tactics employed during the conduct of Board investigations and actions, and be it further

RESOLVED, that MSMA encourage and support legislation directed toward developing a system of checks and balances with regard to the Board's ability to both investigate and assess (tax) physicians.

RESOLVED, this resolution replace the current policy No. 2 in the current policy manual of MSMA.

House Action: The above amended resolution was adopted.

Resolution 28

Amendments and Revisions of the Current MSMA Policy No. 50 - Physician, Right to Choose.

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that MSMA support the right of each physician to determine for him/herself whom he/she will or will not accept as a patient and to excersise his/her choice by the terms of contractual agreements with other physicians, medical groups, third party payors, governmental agency, hospital or other institutions, and be it further

RESOLVED, that this resolution replace the current policy No. 50 in the current policy manual of MSMA.

House Action: The above resolution was adopted.

Resolution 29

Therapeutic Substitutions by Classes of Drugs

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that the MSMA oppose therapeutic substitutions by classes of drugs.

House Action: The above resolution was not adopted.

Resolution 30

Review Panel for Candidates for Appointive Office

Introduced by the Clay-Platte County Medical Society

RESOLVED, That the Executive Committee of the Missouri State Medical Association shall act as a candidate review panel for Association members seeking the endorsement of the Association in their pursuit of appointive office; and be it also

RESOLVED, That such appointive office shall include office and positions in organized medicine and government; and be it further

RESOLVED, That the panel shall pass along to the Council its evaluation of the compatibility of the candidates beliefs with the philosophies of the Missouri State Medical Association, and be it finally

RESOLVED, The the Council shall have final authority to accept or reject any candidate's request for endorsement or financial support in a bid for appointive office.

House Action: The above resolution was adopted.

Resolution 31

Immediate Past President of MSMA on MSMA Executive Committee

See Resolution #4

Resolution 32

MSMA Support of a Data Collection Bill

Introduced by Marvin A. Singleton, M.D., Jasper County Medical Society

RESOLVED, that the Missouri State Medical Association go on policy of supporting a Data Collection Bill which would enable a generation of consumer guide by the Department of Health of the State of Missouri to enable the purchasers and patients to find the best possible services at the most reasonable prices.

House Action: The above resolution was adopted.

Resolution 33

Policy on Contributions to MSMA Members' Campaigns for AMA Elective Office

Introduced by MSMA Council

RESOLVED, that the following shall be the guiding policy for making monetary contributions to Missouri State Medical Association members' bids for elective office in the American Medical Association:

A Missouri State Medical Association member who is interested in running for elective office in the American Medical Association shall:

1. Discuss his or her candidacy with the Missouri delegation to the AMA. The delegation will consider the candidate's qualifications and electability, and will vote to approve or reject support for the candidacy.
2. If the Missouri delegation recommends support for the candidate, the chairman of the delegation will present the recommendation in his or her report at the next Council meeting. If the Council accepts the recommendation to support the candidate, the candidate shall meet with the ad hoc panel consisting of MSMA President, President-Elect, Treasurer, the chairman of the Missouri AMA delegation, and the MSMA staff to discuss financing for the campaign.

   The candidate should be prepared to discuss campaign contributions available from his or her national and state specialty societies, his or her component medical society and hospital medical staff, and his or her personal funds.

   Following this meeting, a campaign budget will be developed. The limits on MSMA contributions shall be $10,000 for campaigns for a Board of Trustees seat, and $5,000 for campaigns for AMA Council seats.
3. The ad hoc review panel shall make a dollar-amount recommendation for inclusion in the full Missouri State Medical Association budget, which is considered and discussed at the December Council meeting.
4. The ad hoc panel shall discuss with the candidate the number of times the MSMA will contribute to his or her campaign(s). Realistically, a candidate who has received Association support in a successful race would probably continue go have MSMA support in his or her subsequent bids for re-election, up to AMA term limitations. Additionally, a candidate may choose to run for a different office in a subsequent year; the panel shall

discuss these options with individual candidates as appropriate.

5. The name of the MSMA candidate, the AMA Office or Council seat he or she is seeking, and the amount of the MSMA's contribution to the campaign shall be published in Missouri Medicine.

6. Following the election, the candidate shall submit a complete accounting of his or her expenses to the Council.

House Action: The above amended resolution was adopted.

Resolution 34

Premarital Testing for Certain Diseases

Introduced by the Chariton-Macon-Monroe-Randolph County Medical Society

BE IT RESOLVED, that the Missouri State Medical Association advise the State of Missouri that, the testing for and reporting of any VD should be resumed including HIV, Serological Test for Syhpilis (STS), and evidence and cause of vaginitis and urethritis for applicants for licenses for marriage, and in pregnancies on the first visit to an attendant. Such attendants may be physicians, physician assistants, nurse practitioners, public health nurses or a public health department.

House Action: The above resolution was not adopted.

Resolution 35

Ear Piercing Guidelines

Introduced by Nancy Bunge, M.D., and the Audrain County Medical Society

RESOLVED, that the Missouri State Medical Association ask the American Medical Association to develop guidelines for ear piercing and to distribute these recommendations to appropriate organizations and the general public.

House Action: The above resolution was adopted.

Resolution 36

MSMA Young Physicians Committee

Introduced by MSMA Young Physicians Committee

RESOLVED, that the Young Physicians Committee be a standing committee of the Missouri State Medical Association.

House Action: The above resolution was adopted.

Resolution 37

Medicare Fee Discrimination Against New Physicians

Introduced by MSMA Young Physicians Committee

RESOLVED, that the Missouri State Medical Association strongly oppose the onerous provisions of OBRA 1990 which currently discriminates in payments to new physicians; and be it further

RESOLVED, that the Missouri State Medical Association establish the elimination of payment differentials for new physicians as a top rank legislative priority for 1992 and beyond, if necessary, with the commitment of appropriate staff resources, and Key Contacts; and be it further

RESOLVED, that the Missouri State Medical Association persistently encourage its Congressional Delegation to co-sponsor House Bill 1898 and its companion Senate Bill, when introduced.

See Resolution #14

Resolution 38

Increasing the Number of Primary Care Physicians Through Student Loan Deferment

Introduced by Metropolitan Medical Society of Greater Kansas City and Kansas City Academy of Family Physicians

RESOLVED, that in order to increase the number of primary care physicians (family practice, general internal medicine, general pediatrics), medical student loans will be fully deferred (no interest or principal payments) for up to three years for those in primary care residencies, and be it

RESOLVED, that for the first five years after residency, primary care graduates with prior loan deferrals must sign a yearly attestation that they are practicing primary care and are not in subspecialty training or they will be subject to the deferred interest plus a penalty, and be it further

RESOLVED, that the MSMA take this resolution to the AMA for consideration and if passed, the AMA pursue all efforts to have this proposal enacted by the United States Congress.

House Action: The above resolution was adopted.

Resolution 39

Obstetrical Care in Missouri

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that the Missouri State Medical Association commence planning a pilot project to establish an alternative birthing center under the control of the University of Missouri Medical School Department of OB/GYN, and be it further

RESOLVED, that certified nurse midwives be licensed to work in Missouri under protocols in hospital and birthing center delivery facilities under medical and osteopathic doctor's supervision to provide this specific care, and be it further

RESOLVED, that certified nurse practitioners be employed to provide prenatal care in medically underserved areas under protocols supervised by physicians who are within easy access (five to ten miles) of the service point.

House Action: The above amended resolution was adopted.

Resolution 40

Insurance Costs as part of Healthcare Costs

Introduced by Metropolitan Medical Society of Greater Kansas City

RESOLVED, that the AMA study the issue of insurance costs as part of healtcare costs; and be it further

RESOLVED, that the AMA discover the amount and significance of payor expenses and profits; and be it further

RESOLVED, that the AMA disseminate this information to the public, the media and state and national legislatures; and be it further

RESOLVED, that the AMA report back to the House of Delegates.

House Action: The above resolution was adopted.

Resolution 41

Sterilization of Patients

West Central Missouri Medical Society

RESOLVED, that the state of Missouri enact legislation that would permit the Medicaid Program to reimburse sterilization of patients who are 18 years old or older.

House Action: The above resolution was not adopted.

Resolution 42

Medicaid Funding

West Central Missouri Medical Society

RESOLVED, that the state of Missouri enact legislation that would limit funding under the Medicaid program to the support of a maximum of two children.

House Action: The above resolution was not adopted.

Resolution 43

Identity of Accuser

West Central Missouri Medical Society

RESOLVED, that the accused doctor(s) be permitted to discover the identity of his or her accuser(s).

House Action: The above resolution was adopted.

Resolution 44

Board of Healing Arts Hearings

West Central Missouri Medical Society

RESOLVED, that the initial hearing by the State Board of Healing Arts may be conducted by telephone conference.

House Action: The above amended resolution was adopted.

Resolution 45

Intitiative for Improved Indigent Primary Care Coverage

Introduced by Metropolitan Medical Society of Greater Kansas City

RESOLVED, that the MSMA seek to expand the State Legal Expense Fund to cover liability for physicians donating primary care, (i.e. free health clinics) to the indigent population of the state by amending Missouri Statute 105.711.

House Action: The above resolution was adopted.

Resolution 46

Increased Physician Participation in Missouri PRO

Introduced by Metropolitan Medical Society of Greater Kansas City

RESOLVED, that physicians in the State of Missouri be allowed to turn in time spent for the Missouri PRO activity for CME credit awarded by the state on an hour basis (maximum 12 hours/year).

House Action: The above resolution was referred to MSMA Council.

Resolution 47

Reporting of Filed Malpractice Suits Against Physicians to the State Board of Registration for the Healing Arts

RESOLVED, that only that aspect of the tort reform law requiring the reporting of filed manuscript suits against physicians to the Board of Registration for the Healing Arts be abolished, and be it further

RESOLVED, that the MSMA Committee on Legislative Affairs pursue legislative action to affect such abolition.

House Action: The above resolution was adopted.

Resolution 48

Survey on Fairness of Present Tort Liability System

Introduced by the St. Louis Metropolitan Medical Society

RESOLVED, that the Missouri State Medical Association survey its membership to determine their opinions on the essential fairness of the present civil justice system and to obtain their opinions on the major areas of reform in the President's Council on Competitiveness report, "Agenda for Civil Justice Reform" which include:

a) expert witness will be required to prove that the opinion they give is based on established theory supported by a significant portion of experts in the field;
b) establish a mechanism so the loser pays the winner's legal fees except in unusual circumstances;
c) limits on punitive damages;
d) reforms to discourage overuse and abuse of discovery;
e) choice of effective alternatives to court adjudication, and be it further

RESOLVED, that the results of this statewide survey of MSMA members be taken to the American Medical Association Interim Meeting 1992 for similar action so that the results may be used to support future efforts at reforming the tort liability legal system.

House Action: The above amended resolution was adopted.

Resolution 49

Medical Student Section Governance

Introduced by the MSMA Medical Student Section

RESOLVED, that this Resolution be referred to the MSMA's Committee on Constitution and Bylaws for consideration, with the instructions that it report findings and recommendations to the MSMA's 1993 House of Delegates; and be it further

RESOLVED, that the action desired is summarized in manner following:

- Amend the MSMA Constitution and Bylaws to create a Medical Student Section (MSS) whereby MSMA's medical students would be governed on a state-wide basis which would unite the four existing medical school component societies. The four component societies would retain their independence, but would be organized under a MSS umbrella.
- The MSS would be governed by a Governing Council consisting of a Chairman, Vice-Chairman, Secretary/Treasurer, and the MSMA Student Councilor and Vice Councilor.
- The MSS will meet annually to elect the Governing Body Chairman, Vice-Chairman, and Secretary/Treasurer.
- The MSMA Student Councilor and Vice Councilor shall be elected, on a rotational basis, by the Medical School Component Societies. These positions would rotate on a sequential schedule - each school holding one position for a one-year term - in the manner of this sequence: Washington University, St. Louis University, University of Missouri-Kansas City, and then the University of Missouri-Columbia.
- Each medical school component society would elect two Delegates (for a total of eight) to represent the MSS in the MSMA House of Delegates at the Annual Convention.

House Action: The above resolution was adopted.

Resolution 50

Physician Collective Bargaining

Introduced by the Buchanan County Medical Society

RESOLVED, that the Missouri State Medical Association establish a policy that there should be a legally mandated formal physician's organization to serve as the physician's representative in all areas of health policy determination, including negotiation of reimbursement, review of the quality and appropriateness of care, review of the appropriateness of payments, and establishment of overall budgetary predictability: and be it further

RESOLVED, that the MSMA establish a committee to explore and define the options and activities necessary to achieve the policies detailed above, including defining what steps are necessary for physicians to engage in collective bargaining; and be it further

RESOLVED, that the MSMA explore the possibility of requiring MSMA membership as a condition of being included in collective bargaining activities; and be it further

RESOLVED, that the essence of the first resolve be referred to the AMA House of Delegates for national action.

House Action: The above resolution was referred to MSMA Council.

Resolution 51

Observation Status

Introduced by James T. Rogers, M.D., and the Greene County Medical Society

RESOLVED, that the MSMA aggressively work to change the RBRVS to inpatient level, and be it
RESOLVED, that the MSMA aggressively work to remove the denials of payments based on technical declaration of status, and be it

RESOLVED, that the MSMA work to have HCFA recalculate DRG's to reflect changes resulting from the "carving out" of short stay admission, and be it

RESOLVED, that the MSMA take this resolution to AMA for their approval and enactment of resolution.

House Action: The above resolution was adopted.

Resolution 52

Pediatric Care in Missouri

Introduced by Nancy Ceasar, M.D., Frederic Hamburg, M.D., and the Greene County Medical Society

RESOLVED, that the MSMA commits its financial resources to investigate the medicaid system in Missouri as it pertains to CHILDREN'S healthcare specifically, and be it further

RESOLVED, that the MSMA studies the issue of access to care for CHILDREN as it relates to inadequate reimbursement rates in violation of federal guidelines.

House Action: The above resolution was adopted.

Resolution 53

Sponsorship of Scientific Articles

Introduced by Norman R. Wall, M.D., and the Greene County Medical Society

RESOLVED, that if a member is the sponsor of a paper, that it be considered a paper presented by a member.

House Action: The above resolution was referred to MSMA Committee on Constitution & Bylaws.

Resolution 54

Further Government Intervention

Introduced by the Cape Girardeau County Area Medical Society

RESOLVED, that the MSMA go on record as opposing any further government intrusion into the practice of Medicine; and be it further

RESOLVED, that the MSMA work in conjunction with the AMA and the major medical specialty societies to mount a campaign to halt any further bureaucratic edicts which come from two different federal bureaus; 1) Health and Human Services and 2) OSHA; and be it further

RESOLVED, that this information be forwarded to the Missouri U.S. Congressmen.

House Action: The above amended resolution was adopted.

Resolution 55

Third Party Payor Billing Practices

Introduced by the Third Councilor Delegate Stephen Slocum

RESOLVED, that the MSMA adopt a policy that the practice of third party payors, who are already collecting the cost of claims processing incorporated into the subscriber premiums, wholly or partially owning billing service to which physicians will have no reasonable alternative but to subscribe to, thereby incurring additional overhead expense which they are prohibited from passing on to the patient, to be inappropriate, coercive and monopolistic, and be it further

RESOLVED, that the MSMA investigate and pursue remedies to such practices through complaint to the Department of Insurance of the State of Missouri, and be it further

RESOLVED, that the MSMA investigate the legal implications of such practices by query to the Attorney General of the State of Missouri.

House Action: The above resolution was referred to MSMA Council.

Resolution 56

Statewide Geographical Adjustment Factor

South Central Counties Medical Society

RESOLVED, that the MSMA House of Delegates strongly encourage the St. Louis Metropolitan Medical Society, the Metropolitan Medical Society of Greater Kansas City and the Clay-Platte County Medical Society to support the adoption of a statewide geographic adjustment factor by HCFA.

RESOLVED, that the MSMA officers and staff continue to explore and pursue any and all other possible options to accomplish adoption of a statewide geographic adjustment factor by HCFA.

RESOLVED, that the position of the MSMA be in favor of the adoption of a statewide geographic adjustment factor by HCFA.

House Action: The above resolution was adopted.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

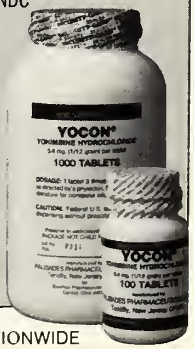
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Committee and Commission Reports

Report of the Committee on Legislative Affairs

Health care costs and access!!!

If you visit the Missouri Legislature, or the U.S. Congress, or watch television, or read newspapers, you know that the topic of "health care costs and access" is a major concern in our state and country.

In Jefferson City, the Canadian-style Universal Health Care System bill (HB 900) was again introduced and received much favorable comment from legislators, the public and the press. A coalition of opponents to the measure composed of the MSMA, Missouri Hospital Association, Missouri Chamber of Commerce, Associate Industries of Missouri, Missouri Managed Care Association and several health insurance companies were able to derail the bill on a 66-85 vote just last week. Supporters of the issue immediately said they would have it placed on a statewide ballot for the people to decide in November.

Meanwhile, leadership in the Missouri House (which had supported HB 900), requested that supporters and opponents of the bill meet to see if anything addressing health care costs and access could be passed this Session. A bill proposed by the coalition referred to above, called the Missouri Health Care Forum, is now under consideration by the Legislature.

The Forum bills, HB 1438 and SB 754, would expand Medicaid eligibility for mothers and infants, encourage small employers to provide employees with insurance, require a universal health care claim form, prohibit providers from "exploding" or "unbundling" insurance claims, require close review of proposed mandated insurance benefits and provide tax credits for small employers offering insurance.

Other "cost issues" before the Legislature include SB 796, which includes health insurance reforms and hospital date reporting; SB 451 and HB 1329, which would establish a Blue Ribbon Commission to study the various health care proposals and report back to the Legislature on which path to follow.

It is premature at this time to predict what the Missouri Legislature will do regarding health care costs during the 1992 Session. it is certain, however, that this shall be an ongoing debate until something is done about the escalating costs of medical care and the estimated 600,000 uninsured and underinsured Missourians.

Cost and access overlap even into issues such as the proposed legalization of the practice of Lay Midwifery in Missouri. House Bill 855, which would allow lay midwives to practice after very minimal requirements, has passed the House and is awaiting a hearing by the Senate Public Health Committee. Proponents of the bill were able to convince the House on a 115-40 vote that physicians are unwilling to locate and deliver babies in areas of need, unwilling to accept Medicaid patients and charged more than many families could afford.

Another cost issue is the Worker's Compensation legislation proposed by the state's business and insurance groups. As originally introduced, SB 605 would have established a physician fee schedule matching the federal RBRVS and set up utilization review procedures in the program. Proponents claim that medical costs are the fastest increasing component of the Worker's Compensation program. Businesses have experienced premium increases of 15% to 30% annually for the past five years. To date, MSMA has been able to eliminate the fee schedule and other sections dealing with medicine from SB 605 and HB 975. However, members can expect added pressure to control medical costs under the Worker's Compensation program no later than next year when the entire program is expected to be overhauled.

An issue receiving abundant press has been HB 1377, which would prohibit physicians from self-referring for physical therapy services where the physician has ownership in the P.T. clinic. Self-referral has come under attack from the AMA, the Medicare Program , Congress and in some independent studies which purportedly show it results in excessive and more costly referrals. After consultation with specialty groups, MSMA was able to have the bill amended to allow for a 2 1/2 year divestiture period and permit physicians to rent or lease to P.T.s at market prices. The Association has withdrawn opposition to the bill, but is concerned it may be expanded to prohibit referrals to facilities such as labs, imaging centers, etc. Members can expect such a proposal to surface this Session and next year.

Another bill that has drawn abundant press coverage is SB 849, which addresses the procedures of the Board of Registration for the Healing Arts. Following many member complaints that the Board was "harassing" physicians, that some of its investigators were rude and that due process was being violated, the Association sought the opinion of defense attorneys who represent physicians before the Board. The attorneys agreed. Proposed legislation was developed and introduced with the desire to begin negotiations with the Board. To date, three meetings have been held with the Board or its representatives, and amended draft of the bill has been prepared and the bill's sponsor has asked the Association and the Board to meet again to consider possible changes in the amended version. Despite charges by some that MSMA is trying to protect "bad doctors", neither the Association nor the bill's sponsor has even requested a committee hearing on the bill until thorough negotiations are completed.

MSMA members can see that medicine is facing many, many important bills in the current Missouri Legislature. This list contains just a few of the more than 300 medically-related bills which have been introduced.

Sadly, while politicians are trying harder to bring about changes in the health care system, it appears that fewer and fewer physicians are willing to take the time and effort to provide these politicians with the information they need to make informed decisions.

Many State Senators and Representatives have said they have not heard from physicians in their area regarding such issues as Universal Health Care, lay midwifery or Workers' Compensation. It is interesting to note more than 200 people in favor of lay midwifery bill attended the hearing and lobbied for its passage.

MSMA members must be willing to convey medicine's opinions to Legislators who vote on the laws that govern our profession, practice and patients.

Your committee urges you to become a Legislative "Key Contact" and to take part in the Physician Involvement Program (PIP). Take time at this convention to contract MSMA staff or write MSMA headquarters, P.O. Box 1028, Jefferson City, MO 65102 for more information.

H. Jerry Murrell, M.D., Chairman
Dorothy D. Reister, M.D.
Carol F. Williams, M.D.
Norman P. Knowlton, III, M.D.
David Wilkinson, M.D.
Melvin C. Kasten, M.D.
Donald McIntosh, M.D.
Frederick W. Hahn, M.D.
David O. Barbe, M.D.
Robert N. Miller, M.D.
Rebecca Lueckenhoff, M.D.
Donald A. Potts, M.D.
Mrs. John Hunkeler
Mrs. David Perkins
Mrs. John Mitchell
Mrs. H. Jerry Murrell

Report of the Commission on Continuing Education and Health Manpower

The Commission on Continuing Education and Health Manpower met on December 3 along with the Committee on Continuing Medical Education. The Committee on Continuing Medical Education met on April 30, July 17, and November 10.

The Committee on CME reviewed and approved the MSMA progress report that was submitted to the Accreditation Council on Continuing Medical Education Committee for Review and Recognition (CRR). The Accreditation Council on CME notified MSMA that this report was accepted and the Committee was commended for their efforts in correcting identified problems.

The Committee reviewed two programs sponsored by the AMA that were being awarded Category I credit - Grand Rounds for Medical Malpractice and Gearing Up for Retirement. These seminars do not constitute the types of clinical educational experiences that has traditional been characteristic of Category I activities. The Committee felt these seminars do not increase physicians' clinical knowledge. In today's climate of accountability, Category I CME must assist Missouri physicians in increasing their professional competence, and not their business operations.

The Committee discussed a tentative date in June of 1992 for the first CME Provider's Workshop in Missouri. This workshop would be targeted to physicians serving on organizational and hospital CME committees as well as hospital support personnel.

The Committee on CME worked with the Missouri Academy of Family Physicians to enable its members to submit their prescribed hours to the Missouri State Board of Registration for the Healing Arts in order to satisfy the relicensure requirements.

The Guidelines for Commercial Support of CME were approved by the Joint Task Force on Pharmaceutical Industry/CME Provider Collaboration in February 1991 and the ACCME approved these Guidelines in March, 1991. The purpose of these guidelines is to describe appropriate behavior of accredited sponsors in planning, designing, implementing, and evaluating certified CME activities for which commercial support is received.

These Guidelines state that an accredited sponsor shall have a policy on conflict of interest applicable to CME activities. All certified CME activities shall conform to this policy.

Committee members reviewed and adopted a "Conflict of Interest Declaration." All speakers will be asked to sign this form prior to his or her participation in the MSMA Annual Convention or other seminars as may be appropriate.

The Committee reviewed 33 Annual Reports of accredited providers for CME. The recommendations of the Committee were forwarded to the respective organization's Director of Medical Education or the CME Chairman.

The Commission adopted a Mission Statement for MSMA and the Mission Statement for MSMA's Annual Convention.

Commission members also reviewed programming for the 134th Annual Convention. This year's preliminary program will contain the program objectives that are based on the specialties needs assessment. Again during this Annual Convention, physicians will be required to complete an evualtion form in order to obtain CME credit.

The Committee members recommended the following be recognized as a sponsor for CME activities.

Boone County Medical Society, Columbia
4 year accreditation

Chariton-Macon-Monroe-Randolph
County Medical Society, Moberly
2 year accreditation

Children's Mercy Hospital, Kansas City
4 year accreditation

Fairfax Community Hospital, Fairfax
3 year accreditation

Farmington Community Medical Center, Farmington
Provisional accreditation for one year

Golden Valley Memorial Hospital, Clinton
2 year accreditation

Incarnate Word Hospital, St. Louis
2 year accreditation

John Fitzgibbon Memorial Hospital, Marshall
2 year accreditation

Kansas City Southwest Clinical, Kansas City
4 year accreditation

Lee's Summit Community Hospital, Lee's Summit
2 year accreditation

Liberty Hospital, Liberty
3 year accreditation

Lutheran Medical Center, St. Louis
2 year accreditation

Memorial Community Hospital, Jefferson City
2 year accreditation

Menorah Medical Center, Kansas City
4 year accreditation

Missouri Baptist Medical Center, St. Louis
4 year accreditation

North Kansas City Hospital, North Kansas City
Provisional accreditation for two years

Phelps County Regional Medical Center, Rolla
2 year accreditation

St. Joseph Hospital, Kirkwood
3 year accreditation

St. Louis Society of Medicine & Scientific Education,
St. Louis
4 year accreditation

St. Mary's Health Center, St. Louis
4 year accreditation

Still Regional Health Center, Jefferson City
2 year accreditation

Trinity Lutheran Hospital, Kansas City
4 year accreditation with accommodations

Western Missouri Mental Health, Kansas City
2 year accreditation

We appreciate the participation of the following Commission members.

John Renner, M.D., Chairman
David S. Martin, M.D.
Gerald J. Duling, M.D.
York E. Silliman, M.D.
Donald C. Patterson, M.D.
James S. Denninghoff, M.D.
William H. Gondring, M.D.
Michael W. Vannier, M.D.
Kathryn R. Roedel, M.D.
Robert B. Brigden, M.D.
James K. Ritterbusch, Jr., M.D.
Nancy H. Ceaser, M.D.
Turner L. Minnigerode, M.D.
Michael R. Freeman, M.D.
George X. Trimble, M.D.

Report of the Commission on Interspecialty Medicine

The Commission on Interspecialty Medicine met on July 18, 1991 via phone conference.

The Commission members discussed the RBRVS and the 16% reduction of the initial conversation factor. The chairman encouraged members to write their members of Congress and HCFA Administrator Gail Wilensky and urge a correction of this situation. An AMA legal analyst supports correction of the conversation factor. State and metropolitan medical societies, including the MSMA, as well as specialty societies, have been active in a letter-writing campaign.

Commission members were reminded that the MSMA's 134th Annual Convention will be held April 9-12, Adam's Mark Hotel, St. Louis, Missouri. Each specialty representative was also reminded of the importance of the moderator critique form and the participant evaluation forms. It was stressed that the evaluation forms will be used to document physician attendance in order to obtain continuing medical education credit and to determine whether or not the program objectives were met. The respective program moderators will be asked to complete the critique forms and pick up the participant evaluation forms to assure that physicians obtain the appropriate CME credit.

The utilization review bill recently passed by the Missouri General Assembly was discussed and a summary of this bill was provided to each member. Commission members also discussed Department of Mental Health budget cuts for 1992 fiscal year totalling $31.5 million.

We appreciate the participation of the following Commission members.

Stephen G. Slocum, M.D., Ophthalmology, Chairman
Robert N. Miller, M.D., Anesthesiology
Dean A. Nierling, M.D., Emergency Medicine
William D. Soper, M.D., Family Physicians
Douglas Westhoff, M.D., Internal Medicine
William J. Crowley, M.D., Neurology
William M. Walker, M.D., Obstetrics/Gynecology
John Yost, M.D., Orthopedics
Kenneth Buchwach, M.D., Otolaryngology
Robert Edmonds, M.D., Pediatrics
Aly Mohsen, M.D., Physical Medicine and Rehabilitation
Steve Soltys, M.D., Psychiatry
Julian N. Verde, M.D., Radiology
Michael Bukstein, M.D., Surgery (Missouri and ACOG)
Michael J. Chehval, M.D., Urology

Report of the Commission on Public Affairs

The Commission on Public Affairs met October 12.

The Commission considered Resolution 13 and 26 from the 1991 Annual Convention, which had been referred to the Commission by the MSMA Council. On the issue of bicycle safety helmets, the commission recommended the MSMA develop legislation to mandate helmet wearing for all ages. On the issue of blood alcohol limits for the legal definition of intoxication, the commission recommended introduction of legislation lowering the BAC limit to 0.08 g/dl and also suggested Dr. James Blaine, Springfield, be invited to write an article on drunken driving for *Missouri Medicine*.

Commission member Dr. Kenneth Dempsey discussed his resolution dealing with Title XIX and its effect on children born into its system. After some discussion of the points Dr. Dempsey raised, Dr. Hoeman suggested that the resolution be submitted directly to the House of Delegates. Dr. Dempsey agreed.

The commission also recommended that the MSMA develop a media seminar, possibly with the Missouri Hospital Association, perhaps at several different sites around the state, and also develop some topics and speakers for the event.

Dr. Hoeman reported that Greene County Medical Society plans to institute a "Mini-Internship Program" in Springfield, using guidelines obtained by the MSMA. The county society hoped to hold a two-day program in time to make a preliminary report at the April Annual Convention. Recruitment of physicians and laypersons is continuing.

Michael D. Hoeman, M.D., Chairman
Daniel J. Brennan, M.D.
Kenneth K. Dempsey, M.D
Ravi Mehra, Jr., M.D.
Warren C. Lovinger, Jr., M.D.
Kimberly W. Hayes, M.D.
Jay Yedlin, M.D.
Jim DeLine, M.D.
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Michaele M. Penkoske, M.D.
Gerald B. Lee, M.D.
Marla J. Tobin, M.D.
Stanley G. Hall, M.D.
Keith A. LaFerriere, M.D.
Stephen Vilmer, M.D., Councilor-Advisor

Report of the Committee on Publications

The 88th volume of *Missouri Medicine* contained 29 scientific articles, 9 special articles, 15 guest editorials and 2 listings of the Final Disciplinary Actions for the Board of Healing Arts. Twelve issues were produced, including the Annual directory issue in August. The average circulation per issue was 6,907.

Editorial topics were diverse, including guest editorials and special articles that dealt with a wide variety of issues. Some topics included the changing role of the physician in society, the beneficial impact that caring, professional physicians have on each other, their patients and the community, and the real, human concern that many physicians bring to the treatment of their patients. Several articles invited Missouri's physicians to take a greater part in developing health legislation in general and to assist with the control of tobacco usage and to strengthen the state's DWI laws in particular. Special articles concentrated on PRO review, Physicians Peer Review, the creation of the National Practitioner Data Bank, Nursing Home Insurance, and possible reforms in health care funding in America. Authors also dealt with the attention that OSHA is now directing towards the medical community and Medicare audits, defending the use of laboratory animals for medical research, and changing patterns in geriatric suicide. And, a rich selection of peer-reviewed scientific articles added to the wealth of medical literature.

Each month, *Missouri Medicine* featured original art work on its covers. Several selections were the work of physicians and all were by Missouri artists. The Annual Membership Directory issue (August) again featured a commissioned work by John Odell, a scene from the St. Louis Botanical Gardens. This was the third time in as many years that Mr. Odell has been featured on the cover of this special publication of *Missouri Medicine*. The art work featured on the magazine's covers continues to be a source of pride for the publication committee.

Ms. Valerie A. Peters resigned as Managing Editor to accept a position with a firm in Alton, IL and Mr. Dennis Weiser, M.S., joined the staff in late September as the new Managing Editor. The Committee expresses appreciation to Ms. Peters for her dedication and extends a warm welcome to Mr. Weiser. As the year drew to a close, a major personnel change was announced as Donald G. Sessions, M.D. announced that he was stepping aside as editor of the journal. The Council accepted his resignation with regret and has named J. Regan Thomas, M.D. as the new editor.

The editors, publication committee members and MSMA staff wish to again express appreciation to all who submitted material to *Missouri Medicine*, the journal of the Missouri State Medical Association. Financial information about the journal is included in the Delegate's Handbook and the Association's 1991 financial report.

The publication committee:
Donald G. Session, M.D., Chairman
Ramona Chapman, M.D.
Jack J. Curtis, M.D.
John J. Daniels, M.D.
Stephen Hamburger, M.D.

Report of the Ad Hoc Committee on "Sunsetting"

The Ad Hoc Committee on Sunsetting MSMA Policies met via conference call on January 24, 1992.

After discussion of several policies and their backgrounds, the Committee recommended sunsetting of the policy titled "Nursing Education," which states:

"The MSMA supports all present forms of nursing education as being essential to meeting the health care needs of the state and local community."(1980)

Dr. Hahn also suggested an editorial change in the policy on "Alcohol Abuse," to reflect the change in name of the Physician Rehabilitation Program to the Physicians Health Program. The Committee concurred.

The Committee believed that several policies could be amended or clarified, but felt that sunsetting the present statements would not be appropriate. Rather, it was suggested that new resolutions dealing with the changes be introduced in the 1992 House of Delegates for a full discussion of the issue and its merits.

Frederick A. Hahn, M.D., Chairman
Gordon M. Goldman, M.D.
A.J. Campbell, M.D.
Robert McQuillan, M.D.
Carl R. Kruse, M.D.

Report of the Physicians Health Committee

The Missouri's Physicians Health Committee met on May 29, 1991, October 19, 1991 and January 18, 1992.

The Missouri State Medical Association has been notified by the Internal Revenue Service that the application for the MSMA Physicians Health Foundation to be recognized as a 501-C3 organization has been approved. An account has been established in Jefferson City in order to deposit funds generated by the Foundation.

The Committee members discussed long-term strategies for the Foundation. These strategies are consistent with developmental efforts for charitable service organizations. The ongoing fundraising activities will continue with emphasis being given to utilizing these monies in a cost effective manner.

The Physicians Health Committee will be submitting articles to *Missouri Medicine* in order to keep the MSMA membership informed of the Committee's activities. These articles will also include various aspects of physician impairment.

The medical director and program coordinator will be meeting with the chief executive officer, president of the medical staff, and other designated hospital representatives to establish a close working relationship. In addition, Committee members will continue their efforts in promoting the PHP during their respective hospital medical staff meetings and hospitals in their respective areas.

Participants will be charged a $50 administrative fee beginning on their 13th month of recovery to defray monitoring costs. In reviewing participant's accounts, several were identified as being delinquent. The committee has been directed to forward a letter to these participants in order to make arrangements to pay their account in full.

The Committee has asked for an opportunity during the MSMA 134th Annual Convention to sponsor a scientific program. This program will be held on Friday immediately following the MSMA's General Session.

The medical director of the PHP has met on several occasions with members of the Missouri State Board of Registration for the Healing Arts to discuss ways to improve the relationship between the Board and the Missouri's Physicians Health Program. These activities continue to be ongoing.

The Committee will use the Salvia Alcohol Test as an option for monitoring program participants. This test is recommended for professional use in the evaluation of persons suspected of being intoxicated as an aid in the management of alcoholism. Physicians tested will be responsible for the cost of this monitoring.

The PHC expressed its sincere appreciation to the hospital administrations and medical staffs of Missouri hospitals that have financially supported the activities of this Committee. It is this support that will assure the continued success of this program. Hospitals that have made contributions to the Physicians Health Program will be recognized in *Missouri Medicine*.

Thomas R. Anderson, M.D., Chairman
Jack L. Croughan, M.D., Medical Director
Karen Sanders, Program Coordinator
Hugh E. Bartlett, M.D.
Jo-Ellyn Ryall, M.D.
Edward M. Grim, M.D.
Diana J. Spade, M.D.
James R. Criscione, Jr., M.D.
Edward C. Felker, III, M.D.
Thomas M. Ahmann, M.D.
Donald M. McIntosh, M.D.

Report of the Commission on Medical Economics, Third Party Medicine and Governmental Relations

The Commission on Medical Economics, Third Party Medicine, and Governmental Relations met on September 14, 1991, in Jefferson City, Missouri.

The Commission received six resolutions as referred from the 1991 Annual Convention:

Resolution #5 - *Insurance Carrier's Discriminate Denial of Full Entitled Payments to Allergy Patients*
RECOMMENDATION: The Commission recommended to Council that the resolve of Resolution #5 (A-91) be deemed official MSMA policy and that it be enrolled into the MSMA Policy Manual.

Resolution #11 - *Regulation of Managed Care*

The Commission dicussed this resolution at length. While the consensus was that this isue is a contractual one and is probably not within the purview of organized medicine, there was genuine concern that some managed care programs are discriminating against osteopathic physicians by refusing to offer them participation contracts. The Commission instructed MSMA staff to ask the Missouri Association of Osteopathic Physicians and Surgeons if data can be found, the Commission will recommend that Resolution #11 not be adopted and ask its author to resubmit it with supporting data during the 1992 MSMA Annual Convention. If compelling evidence can be found to indicate routine discrimination, the Commission will meet again to determine an appropriate course of action.

Resolution #12 - *Improvement and Expansion of Medicaid Services by Adjudication*

RECOMMENDATION: The Commission recommended to Council that no action is needed by the Commission at this time.

Resolution #24 and #25 were considered together.

Resolution #24 - *Access to Medical Record Information*

Resolution #25 - *Confidential Information Requested by Insurance Companies*

RECOMMENDATION: The Commission recommended to Council that the MSMA should make every effort possible to ensure that the regulations promulgated by the Missouri Department of Insurance pursuant to the 1991 utilization review legislation will limit access to and protect the confidentiality of medical records.

The Commission further recommended to Council that MSMA staff publish an informational article in *Missouri Medicine* and/or *Progress Notes* regarding current laws, opinions, and policies on access to medical records.

The Commission then considered Resolution #19 (A-91) and Resolution #1, a tabled measure from the MSMA's 1989 Annual Convention.

Resolution #19 - *Medical Ombudsman to Investigate Bureaucratic Incongruities*

Resolution #1 (A-89) - *Physician's Grievance Committee*

RECOMMENDATION: The Commission recommended to Council that a Blue Ribbon Committee be appointed to oversee the development of a new office within the MSMA which will serve as a formal grievance mechanism and liaison between physicians and third party payors.

The Commission recommended that the MSMA hire and train additional staff to assist all physicians statewide in resolving coding problems, reimbursement discrepancies, programmatic incongruities, and other related grievances with third party payors. These activities would include seeking clarification and interpretation of regulations and policies as well as developing a framework of communication to guide and influence future policy-making by insurers.

While much of the mechanical and organizational detail work should be entrusted to the Blue Ribbon Committee, this Commission recommended the following as basic, minimal functions and activities:

☐ Provide a clearinghouse for ombudsman activities, serving as an official liaison to resolve conflicts between physicians and insurance companies, contract health providers, HMO's, PPO's, such large third party payors as General American and Blue Cross/Blue Shield, and government programs such as Medicare and Medicaid.

☐ Coordinate meetings - beginning in early 1992 - to establish routine dialogue and cooperative communication with the major third party payors in the state.

☐ Coordinate activities with the MSMA's local component medical societies which have existing physician grievance programs.

☐ Coordinate activities and exchange ideas and information with the various specialty societies which are pursuing similar agendas.

☐ Ultimately establish a permanent committee or commission of physicians to oversee all ombudsman activities. It is expected that the Blue Ribbon Committee would be phased out as the ombudsman program matures.

☐ Maintain a liaison with the Missouri Department of Insurance, the Missouri Division of Medical Services, and HCFA.

The Commission recommended that work on this important project start immediately, with the goal of beginning operations by January 1, 1992. The Commission also recommends that Carl Strauss, M.D., serve as Chairman of the Blue Ribbon Committee.

Frederick G. DeFeo, M.D., Chairman
Melvin R. Hayden, M.D.
Ann C. Peick, M.D.
Carl Strauss, M.D.

James T. Rogers, M.D.
James T. Conant, M.D.
Paul D. Thompson, M.D.
John Mentel, M.D.
Alan L. Braun, M.D.
Alfred D. Shaplin, M.D.
Luis B. Anglo, M.D.
Joe Pryor, M.D.
Ronald N. Riner, M.D.
J. Gustavo Nix, M.D.
Milamari A. Cunningham, M.D.
Steven E. Buie, M.D., Council Advisor

Report of the MSMA Professional Liability and Tort Reform Blue Ribbon Committee

The MSMA Professional Liability and Tort Reform Blue Ribbon Committee met on August 3-4, 1991.

The day and half meeting was facilitated by Dr. Robert Brittain, President, Medical Liability Consultants Programs, Inc., Denver, CO, who is recognized as one of the nation's experts in the area of medical risk management.

Dr. Brittain explained how the Colorado risk management program works and pointed to specific reasons: (1) Why patients contact attorneys; (2) Why physicians lose malpractice suits; and (3) Why phyicians lose more than they should.

Dr. Brittain stressed that a Risk Management Program should seek out "correctable" problems and problems that result in high dollar losses. He also stated that most current risk management programs are operated on a "reward/punishment" basis. He pointed out that Colorado and a few other states have an advantage over Missouri in this area, since they have one medical malpractice insurance carrier or one very dominant carrier. Those states can then work with the insurer to develop rewards and punishments. When there is widespread carrier competition such as in Missouri, such a system is more difficult to establish.

After extensive discussion among all participants, the MSMA Professional Liability and Tort Reform Blue Ribbon Committee endorsed the following policy statement and recommendations.

The Blue Ribbon Committee was charged by the Council to define liability problems. The charge was the result of Resolution #30 adopted by the MSMA House of Delegates April, 1991 which read:

> "**RESOLVED**, that the MSMA authorize the Professional Liability and Tort Reform Blue Ribbon Committee to design and establish a Risk Management Program for the members of the Missouri State Medical Association. This program should be represented to the MSMA Council at its August meeting. The program will be implemented upon approval of the Council, and be it further
>
> **RESOLVED**, that at the same time, this Committee also develop a tort reform legislative package to be presented to the Legislature at the appropriate time."

Other states have tackled this problem and clearly data collection of a specific state's areas of liability, judgements, and payments are critical to direct a solution program. Identification of reasons why indemnity monies are paid *in Missouri* is necessary in order to target areas of potential correction and reversal of trends.

The "Blue Ribbon" Committee recommends:

I. That we define Missouri's problem - discussion with liability insurance companies, the Commissioner of Insurance and the State Board of Registration for the Healing Arts regarding data on closed cases will be needed.

II. Once the scope of the problem is more defined, then a long-term subcommittee of MSMA should explore and define a risk management program to educate, inform and try to change practice habits in order to lessen exposure; paramount in this risk management approach is attention to documentation of medical records. The medical record will not be the solitary focus of investigation. Quality of medical care, physician-to-physician relationships, systems of monitoring application of diagnostic studies into treatment application will all be addressed. Increased informed consent and improved consent forms will also be necessary.

Specialty societies will be involved in coordination of the risk management program. Improvement in patient care through heightend awarness of exposure and risk management training should occur. The risk management program would include educational programs designed to stress specific changes in practice habits. Continuing Medical Education credits for risk management training should be available.

III. It is likely that MSMA will promote a pilot voluntary program to test the validity of this approach. This pilot study will include a self-assessment program addressing patient contact, quality of care, and medical record contact.

Indentification of why ***Missouri*** physicians lose legal confrontations is the first task of the long-term committee. Indentification of ***correctable*** causes of liablity exposure is the second task of the long-term committee.

IV. When Missouri Medicine's house is in order, perhaps legislative pressure and careful indentification of the legal community's strategy will accomplish ***real*** improvement in patient care and more harmonious medical practice.

FISCAL NOTE - We do not feel this would have a significant fiscal impact at this time. It will be necessary to develop a budget item in the near future.

Patrick Harr, M.D., Chariman
Michael K. Bukstein, M.D.
Daniel F. O'Sullivan, M.D.
Karl Hasik, M.D.
Gerald Orth, M.D.
Phillip M. Hornbostel, M.D.
Pierre W. Keitges, M.D.
James R. Cook, M.D.
Barry J. Bass, M.D.
Michael C. Trueblood, M.D.
MSMA Executive Committee - Ex Officio

It's a pleasure! ... Auxiliary President Mary Hunkeler introduces the new president for 1992-93, Marge Perkins, to the auxiliary. Marge, an avid golfer, plans to "Go For(e) It!" to make her year of leadership as successful as this past year.

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Summons

The MSMA's Young Physicians' Commitee presented a mock trial for malpractice that was open to all physicians attending the convention.

Dr. Nancy Bunge, a pediatrics physician from Mexico, Missouri, above center, gave expert testimony to the court during the Young Physician's MOCK TRIAL. Steven Woodley and Robert Rosenthal were the attorneys and Thomas McGuire was judge. Volunteers from the audience served as jury members.

CAUCUS

Jonathan Dehner, M.D., above left, and Gordon R. Garrett, Ph.D., lead the Third District delegation in a discussion of the issues that will be considered by the House of Delegates. Dr. Dehner is president and Dr. Garrett is executive vice president of the St. Louis Metropolitan Medical Society.

134th Annual Convention Registration by District

First Council District

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John R. Dixon, Brookfield
Leanna M. Hoffman, Hamilton
George Mandler, Chillicothe
John Martin, St. Joseph
Charles Siegel, Gladstone
Robert W. Smith, Brookfield
Fred Thompson, Liberty
R. Thompson, Moberly

Third Council District

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Charles Andrees, St. Louis
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Larry Arius, St. Louis
Sedat M. Ayata, St. Louis
Farid D. Azzam, St. Louis
Alan H. Backer, Jr., St. Louis
M. Bashiti, St. Louis
John Bedwinek, St. Louis
Susan Berdy, St. Louis
Arjun Bhattacharya, St. Louis
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Seymour Brown, St. Louis
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Evan Crandall, Chesterfield
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James S. Criscione, St. Louis
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Lucan V. DelPriore, St. Louis
Ananda DeSilva, Hazelwood
Pablo De Ungria, St. Louis
Anson E. deVera, St. Louis
Jacquelyn B. Dilworth, St. Louis
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Rich Gahn, St. Louis

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Lance Gerowin, St. Louis
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Duane Hagen, St. Louis
A. Harrell, St. Louis
George Hawkins, Creve Coeur
Henry H. Macler, St. Louis
Tom Heston, St. Louis
William F. Hoffman, St. Louis
P. C. Hogan, St. Louis
Russell Holman, St. Louis
S. Horenstgin, St. Louis
Richard Huck, St. Louis
Robert G. Hughes, St. Louis
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James A. Junker, St. Louis
Stephen Kamenetuky, St. Louis
Hank Kaplan, St. Louis
N.B. Kappesser, St. Louis
M.Y. Karmin, St. Louis
R.M. Keltner, St. Louis
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Rodney Knight, St. Louis
Mary Jane Kohn, St. Louis
Allan E. Kowler, St. Louis
P. Korenblat, St. Louis
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William Klaybill, St. Louis
Bruce Kraemer, St. Louis
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Lester Wall, St. Louis
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Seth Wissner, St. Louis
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Tim Zoys, St. Louis

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Qalbani Mahmood, St. Charles
Martin Willman, St. Charles

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Russell Burton, Columbia
Joseph A. Cornrou, Mexico
Fred Creech, Columbia
William J. Crowley, Jr., Columbia
Milamari Cunningham, Columbia
Curt Vogel, Columbia
W.F. Davisson, Jefferson City
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Nasrul Huq, Mexico
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Ron Swinfard, Columbia
R.H. Tanner, Jefferson City
Steve Taylor, Mexico
Kurt D. Walker, Columbia
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Joe Werth, Jefferson City
Douglas Westhoff, Jefferson City
Kulangara P. Zacharias, Columbia
Thomas D. Zink, Columbia
Susan Zurowski, Columbia

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M. Ted Moore, Nevada
Richard Raynor, Marshall

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Steve Buie, Kansas City
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Jerry W. Cook, Kansas City
Doug Gehning, Independence
G. David Dixon, Kansas City
John Ellis, Blue Springs
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Tom Helling, Kansas City
George P. Hoech, Jr., Kansas City
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John Kyger, Indenpendence
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Andrew McCanse, N. Kansas City
F. McKee, Overland Park, KS
Sam Page, Kansas City
Patrick Price, Blue Springs
John Renner, Kansas City
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Alfred D. Roth, Mission, KS
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Mark Steele, Mission, KS
James Stewart, N. Kansas City
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Nancy R. Waxman, Leawood, KS
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Raymond Christy, Springfield
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Paul Hilton, Joplin
Bill Horton, Springfield
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Kenneth E. Knaff, Springfield
David Magan, Everton
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Bill Prater, Springfield
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D.L. Spalding, Springfield
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Nalini A. Reddy, West Plains
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Mark Vandewalker, Rolla
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Kap E. Jung, Fredricktown
Darrell Griffin, Farmington
Gordon L. Johnson, Crytal City
E. L. Jordan, Jr., Joplin
Walter T. Judge, Crystal City
Christopher H. Jung, Cape Girardeau
Ernest Levenson, Popular Bluff
Ina Levenson, Popular Bluff
Diosdado L. Maranan, Arnold
Ann L. Peick, Popular Bluff
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Summary of Council Minutes 1991-1992

Meeting of April 7, 1991
Westin Crown Center, Kansas City

Dr. Melvin Kasten was elected chairman of the Council and thereby became the presiding officer. Dr. H. Jerry Murrell was elected vice chairman.

Dr. Norman Knowlton III and Dr. David Wilkinson were re-elected MSMA Secretary and MSMA Treasurer, respectively.

Meeting of June 2, 1991
Holiday Inn, Lake of the Ozarks

Councilors approved MSMA sponsorship of a number of workshops to be held around the state.

Dr. Reister gave her report, outlining the many meetings she had attended since April.

Councilors reviewed and approved a report of actions on resolutions from the 1991 Annual Convention.

Dr. Murrell gave a report from the Legislative Affairs Committee.

Dr. William Shell, president of the PRO, reported that the Missouri Patient Care Review Foundation was awaiting word from HCFA on the fourth scope of work, and that the PRO's Cape Girardeau office was to be phased out. He said the PRO has issued one sanction thus far, and has referred one physician to the State Board.

Dr. Hugh Stephenson, Missouri delegation chairman, presented his view of the upcoming AMA Annual Meeting, including his bid for re-election to the AMA Council on Medical Education.

Dr. William Dorzab, HMSS chairman, proposed several changes for increasing the effectiveness of the Section, mainly through improving communications and giving more responsibilities to Section leaders. The Council referred the proposal to the Executive Committee.

CME accreditations, as recommended by the Commission on Continuing Education, were approved.

Dr. Richard Bradley, president and CEO, gave an update on MOMEDICO's activities, including risk management courses.

Meeting of August 25, 1991
Capitol Plaza Hotel, Jefferson City

The Executive Committee made its recommendation to adopt Dr. Dorzab's proposal to expand the duties of the HMSS. Councilors accepted the recommendation. The HMSS now has increased input into MSMA meetings and increased communication avenues internally.

A proposal to have an "Ombudsman Program" for third-party payer issues was referred to the Commission on Medical Economics. The Budget and Finance Committee was charged with studying the issue of MSMA contributions to campaigns for AMA office.

The Blue Ribbon Committee on Liability and Tort Reform presented its report. It recommended and the Council concurred, that the MSMA should begin a formal risk management program, that a committee identify Missouri's liability problems so they can be tackled effectively, and that results from the complete program be used to effect genuine improvement in the whole liability situation.

Dr. Gordon Goldman, St. Louis Councilor, presented a proposed statement on BasicBlue, the new insurance policy for low-income persons that was developed by Blue Cross/Blue Shield. The statement expresses concern that the policy leaves gaps in coverage and financial risk for physicians.

Board of Healing Arts Executive Director Fred Tromans addressed the Council on several matters of concern, including CME requirements and acceptance of certain types of CME.

After some discussion about MOMEDICO's recent payment of a dividend to stockholders, Councilors voted to have a "white paper" on the history of the company, including previous stock transactions and the recent dividend issuance, to be published and made available at the component medical societies.

Councilors voted to increase funding for Resident Physician Section attendance at AMA meetings.

The Commission on Continuing Education presented several recommendations for CME reaccreditation, which were approved.

An Ad Hoc Committee on AIDS was appointed. The following actions were also taken:

- Approved signing a memorandum of understanding with a Kansas City U.R. group.
- Approved RBRVS workshops
- Approved nominations for the Board of Healing Arts.
- Approved nomination for the PRO board.

Meeting of December 15, 1991
Ramada Inn, Jefferson City

The 1992 budget was presented by Dr. Wilkinson and approved by the full Council. Included in the budget was funding for a staff ombudsman for third-party payer issues.

It was announced that the Physicians Health Foundation, which aids impaired physicians, has received 501(c)(3) non-profit status. Contributors to the Foundation may now deduct their contributions from their federal taxes.

Dr. Goldman expressed his concern over MSMA endorsement of various member services, such as insurance plans. His motion, referred to the Executive Committee, asked for legal opinion on the liability such endorsements may impose on the Association.

A statement on qualifications and guidelines for physician expert testimony was considered and referred to the Legislative Affairs Committee. Study and action will be taken.

The Legislative Affairs Committee also presented its lengthy review of legislative issues facing the Association this year. A number of positions and statements were affirmed.

The Committee also received a directive to examine the Board of Healing Arts' most recent license fee increase and budget request. The Executive Committee was charged with studying the Board's new CME rules. On a further license issue, Councilors voted to express disapproval of questions regarding psychiatric treatment and drug abuse that appear on the renewal form. These questions were removed in 1989 from the form, but the latest Board reinstituted them.

Mr. Tromans, of the State Board of Healing Arts, addressed the Council and expressed his willingness to meet with physicians' groups.

Dr. David Barbe, District 9 Councilor, reported on his district's concern over the rural-urban payment differential under Medicare. He proposed that the MSMA seek a "single-site" payment system for Missouri to eliminate the differential. The Council concurred.

Several workshops were approved.

Meeting of February 2, 1992
Capitol Plaza Hotel, Jefferson City

Several resolutions were approved for Council support and submission at the 1992 Annual Convention.

Dr. Kasten presented various recommendations from the Executive Committee. The Council approved the recommendations, which included approval for comprehensive major medical plan changes, and a plan for screening would-be AMA candidates before granting MSMA endorsement and financial support.

A final statement regarding BasicBlue was reviewed and approved, which states, in part: "MSMA publicly states that it supports the efforts of Blue Cross and Blue Shield of Missouri for publicly demonstrating commitment to the uninsured by providing low cost insurance for those who might not otherwise be able to afford it. However, the BasicBlue policy still represents significant underinsurance when compared with benefits in traditional coverage ... Individuals should act independently when full and complete information is available to either accept or reject the contract offer and fee schedule."

The Budget and Finance Committee's recommendation to divest the MSMA investment portfolio of stock in any tobacco interests was adopted. Councilors also agreed with the recommendation to contribute $1,000 to the Missouri Rural Health Program, conducted through the University of Missouri Extension.

The Council accepted reports from the Missouri Patient Care Review Foundation, MOMEDICO, and Dean Lester Bryant, M.D., MU School of Medicine.

Dr. James Wolfe spoke about the Medical Research Center, which has been formed to begin analyzing data on practice variations and the nature of "outliers" around the state.

In other action, the Council:

- Approved the appointment of J. Regan Thomas, M.D., St. Louis, as editor of *Missouri Medicine*.
- Voted to fund AMA delegation attendance at Council meetings, including Annual Convention meetings - the number of funded slots to match the number of official delegates, with the delegation deciding which physicians shall attend.

- Took action on legislative matters now pending.
- Accepted recommendation that the AMA delegation encourage the AMA to produce its promised "model" state legislation on Health Access America.

Meeting of April 8, 1992
Adam's mark Hotel, St. Louis

The minutes of the February 2, 1992 meeting were approved.

Royal Cooper, executive vice president, reported that to date 86% of the membership had paid their 1992 dues. He also announced that MSMA had been selected as one of six pilot sites for the AMA Risk Management Project and that $25,000 had been contributed to the program by the Association, that 250 primary-care physicians need to be recruited, and that the Executive Committee and the Professional Liability and Tort Reform Blue Ribbon Coomitte will meet with the AMA staff on May 13 in Jefferson City to receive a briefing on the program.

He urged support for legislation being advanced in Washington to eliminate the Medicare payment reduction for young physicians (S 2362 and HR 4507).

The Council approved recommendations that the Ad Hoc Committee be converted to an Advisory Committee to the MSMA Council, and that Foreign Medical Graduates (FMG) be identified by the term International Medical Graduates (IMG) and that the Advisory Committee be charged with maintaining close communication with IMGs in Missouri.

The Council approved the following proxies: Proxy for MSMI - Drs. Howard McAlhany and H. Peter Ekern and Royal Cooper; Proxy for MOMEDICO Annual Meeting - members of the Executive Committee and Royal Cooper.

Dr. Dorothy Reister, President, asked the Councilors to provide her with nominations for appointments to the Nominating Committee. The Council also approved the following nominees to the Publications Committee and Editorial Board: Publications Committee - Drs. J.Regan Thomas, Ramona Chapman, Philip Anderson, John Anderson, Mark Steele, Kirby L. Turner, Jay P. Marshall, William H. Crosby, Donald Miller, John S. Daniels, Elizabeth James, Keith Rich, Albert J. Bonebrake, Robert K. Skillman, John Hagan, III, William P. Thorpe, William E. Davis, Louis Dehner, Martin B. Wice, Leroy Young, J.C. Corvalan, Elizabeth J. Syzek, Kirk Nichols, George M. Austin, and Arthur H. Gale.

The Council also approved actions taken by the Executive Committee as outlined by Dr. Reister.

Mrs. Mary Hunkeler, President of the MSMA Auxiliary, introduced Mrs. Marge Perkins, incoming Auxiliary President, and thanked the Councilors for their support during her term.

The Council approved Continuing Medical Education (CME) accreditations to Cass Medical Center - 2 years; Barnes/St. Peters - 3 years; and St. John's/ Washington - 2 years. The Council also approved a recommendation that the Legislative Affairs Committee be directed to use the "Selected MSMA Component Societies' proposal to the Legislative Affairs Committee for the 1992 Missouri Health Care Reform" 9/28/91, as the basis for model legislation for the 87th Missouri General Assembly, First Regular Session, 1992. Dr. Jerry Murrell, Chairman of the Legislative Affairs Committee, said the document would be part of the discussion for legislation in 1993 but that the MSMA does not draft or introduce legislation.

The Council approved a resolution made by Dr. Fred Peterson that calls state agencies who require professional medical review services utilize already existing Missouri review corporations that can meet the agency's requirements and that copies of this resolution be sent to all state agencies and the members of the Legislature.

After hearing from Dr. Arturo Montes, the Council endorsed the following statement as a response to any request for a physician's DEA registration number:

"It is the DEA's policy that a DEA registration number is unique and was designed to impose a 'closed system' on the prescribing, dispensing and administering of illicit controlled substances. It is not intended to be an identification number. The intended purpose of a DEA registration number is to provide a record of authorized possession and responsibility for a controlled substance in accordance with the Controlled Substance Act.

The DEA does not endorse the use of a registration number by insurance companies or others for any reason inconsistent with its intended purpose. Prescriptions for controlled substances will, of course, display a DEA registration number; however, insurance companies or claim processors cannot demand a DEA registration number on a prescription for a noncontolled substance."

The Council heard reports from Dr. Jack Croughan, Physicians Health Committee; Dr. Charles Barbee, Hospital Medical Staff Section; and a brief welcome from Dr. Jo-Ellyn M. Ryall, Speaker of the House of Delegates.

Courtesy Resolution on Deceased Members

WHEREAS, there have been 60 deaths among members since the 1991 Annual Convention, and

WHEREAS, each of these members is missed as an individual as well as for his/her contributions to the practice of medicine and to the Missouri State Medical Association, and

WHEREAS, the loss of each member is felt by all members, as well as his/her loved ones, and close associates and the patients he/she has served with dedication, therefore be it

RESOLVED, that the House of Delegates now pay personal tribute by standing for a moment of silence in memory of each of the 60 members we have lost and whose names will be recorded in the minutes of this Annual Convention.

Members deceased since the 1991 Annual Convention

Morris Abrams, St. Louis
Roger Allbee, Fetus
William Ames, St. Joseph
Ivan A. Anderson, Bettendorf, IA
Herbert Arnold, Lemar
Joseph Bauer, Manchester
Claude R. Bruner, Camdenton
Mary Ann Butler, Hannibal
Jack Cokrhame, Florissant
George A. Cowan, Kansas City
George Craft, Troy
Galvin Curtis, Shawnee Mission, KS
Max Deutch, St. Louis
Penco T. Dzundzev, St. Louis
Eugene H. Ebel, Manchester
Donald Eggleston, Macon
Ronald Elkins, Springfield
C. Howe Eller, Santa Fe, NM
Lawrence Feltz, Perryville
Robert Ferguson, Joplin
Thomas Ferrell, Springfield
Alfred Fleishman, St. Louis
Max Franklin, St. Louis
George Gary, Marceline
Merriam Gearhart, Bethany
David Hammond, Chesterfield
Aaron Hendin, St. Louis
William C. Hummel, St. Louis
Wilfred "Bill" Hurst, Joplin
J.T. Jean, St. Louis
Bert Klein, Arcadia, MI
George Klinger, Sr., Turners
Lyle B. Knight, Lee's Summit
George Lawrence, Meza, AZ
Edwin McCall, Kalamazoo, MI
James R. Meador, St. Louis
Bin Mou, Nevada
James W. Owen, Bartlesville, OK
Sidney F. Pakula, Kansas City
John Platz, Carrollton
Cleitus Presnell, Ft. Myers, FL
William S. Redmond, St. Joseph
G.R. Ridings, Cape Girardeau
Ernest Robinson, Kansas City
T. Eugene Ruff, Poplar Bluff
Carlos Santoro, Kansas City
Richard Schutz, Liberal, KS
Herbert Shuey, Olathe, KS
Eugene Schwartz, Springfield
Wayne Simril, St. Louis
Danny Smith, St. Ann
James C. Steele, Hannibal
William E. Taylor, Springfield
William Utterman, Ste. Genevieve
J. Loren Washburn, Versailles
Robert S. Weinhaus, St. Louis
John Wells, Kansas City
Ora E. Whitsell, St. Joseph
Alvon Winegar, Jefferson City
Daniel Yancy, Springfield

Dr. Steven Buie, District 7 delegate, above, debates Resolution #45 which concerns improved indigent care coverage during a meeting of Reference Committee A.

Dr. Gordon Goldman, left, debates Resolution #23 which concerns the inappropriate use of a physician's DEA registration number.

Dr. Newton White, a 3rd District delegate, asks for clarification during a meeting of Reference Committee A.

"We recommend.."

Work is done in Reference Committees to guide decisions made during the general sessions of the House of Delegates.

MSMF ANNUAL MEETING 1992
ADAMS MARK HOTEL, ST. LOUIS

The Annual Meeting of the Missouri State Medical Foundation was called to order by Miles C. Whitener, M.D., President. The minutes of the 1991 Annual Meeting were approved as published in the July 1991 issue of *Missouri Medicine*.

A motion was made and seconded to re-elect the current officers of the Foundation. The officers of the Foundation for the 1992-1993 term are:

President - Miles C. Whitener, M.D., St. Louis
Vice President - Frederick W. Hahn, M.D., Kansas City
Secretary/Treasurer - Robert H. Tanner, M.D., Jefferson City
Assistant Secretary - Wilma Sperry, MSMA Staff, Jefferson City

The following physicians will serve on the MSMF Board of Trustees:

Robert O. Schaaf, M.D.
Patrick B. Harr, M.D.
Donald Fakhoury, M.D.
Christopher H. Jung, M.D.
Mary E. S. Case, M.D.
James Allan, M.D.
Robert Tanner, M.D.
Miles C. Whitener, M.D.

Regarding new business, the Foundation Board considered a proposal from Sid Dulle, CPA, to transfer $350,000 from a bank account to a Prudential Bache Securities Investment Management Account to increase interest yield during the year. Funds are currently held in a checking account and a money market account, with a combined average balance of about $500,000. The current yield on these funds is 3.76%. Action was postponed pending more information regarding fees, penalties, or other expenses that might be associated with making withdrawals from such an investment account.

The Board agreed to change the start date on loan repayments from July 1st until September 1st to allow residents time to receive one or two paychecks before they start making payments to the Fund.

Ms. Sperry reported that since increasing the maximum loan amount from $2,000 in 1990 to $4,000 in 1991, the total loaned was $372,280. Last year's total was $163,000.

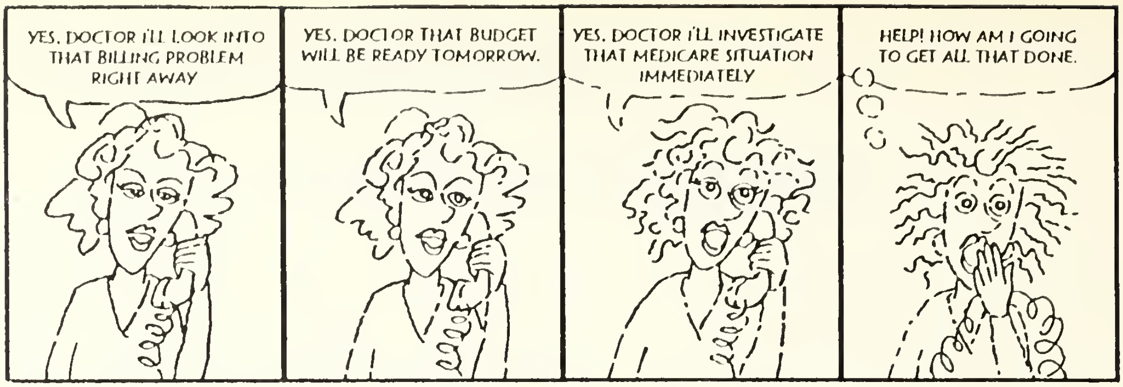
The meeting was then adjourned.

PRESIDENTS
PAST & PRESENT

Carol F. Williams, M.D., left, president-elect for the 1992-1993 term of the Missouri State Medical Association, and Dorothy D. Reister, M.D., president during the 1991-1992, term share a moment during Dr. Williams' presidential inauguration ceremony that was held Saturday, April 11, 1992.

List of Exhibitors

#22 Automated Professional Management, Inc., St. Louis
#23 Baird, Kurtz & Dobson, CPA's, St. Louis
#19,20 Blue Cross and Blue Shield of Missouri, St. Louis
#87 Bock Pharmacal Company, St. Louis
#35 Boehringer Ingelheim Pharmaceuticals, Inc., Ridgefield, CT
#81 Bristol Laboratories, Evansville, IN
#72 Brown's Medical Supply, St. Louis
#73 Challenger & Hunt, St. Louis
#31,33 Ciba-Geigy Corporation, Rosemont, IL
#54 Commerece Bank, Kansas City
#25 Compliance Coordinators, Inc., Kansas City
#91 Correctional Medical Systems, St. Louis
#12 Disability Determinations, Jefferson City
#53 Elaine M. Doroff/Physicians Consultants, Inc., St. Louis
#47 Excalibur Software, Ballwin
#39 Fisons Pharmaceuticals, Columbia
#14 Forrest T. Jones and Company, Inc., Kansas City
#65 Fukuda America Corporation, Redmond, WA
#8 FutureGuard, St. Louis
#66 General American/Medicare Part B, St. Louis
#90 Glaxo, Research Triangle Park, NC
#57 Glaxo, Inc., Overland Park, KS
#15 GTE Data Services, Jefferson City
#37 The Guaranty Trust Co. of Missouri, Clayton
#92 Healthcare Information Systems, Inc., Kansas City
#7 Healthcare Administrative Services, Inc., Kansas City
#18 Healthcomp Services, Inc., Florissant
#46 Hoechst-Roussel Pharmaceuticals, Inc., St. Charles
#89 J.B. Lippincott Co., Novlesville, IN
#1 Kemper Consulting Group, St. Louis
#84 The Key Co., St. Louis
#5 Logos High School, St. Louis
#28 Marco Technologies, Jacksonville, FL
#9 Mayer Hoffman McCann, Kansas City
#80 Mead Johnson Pharmaceuticals, Evansville, IN
#6 The Medical Protective Company, St. Wayne, IN
#17 Medical Defense Associates, Springfield
#71 Medical Employment Directory, Kansas City
#48 Missouri National Guard, Jefferson City
#82 MOMEDICO, St. Louis
#2 Moneta Group, St. Louis
#86 Norwich Eaton Pharmaceuticals, Inc., Norwich, NY
#4 Office Tech., St. Louis
#55,56 P.I.E. Mutual Insurance Co., Cleveland, OH
#36 Paradigm Insurance Company, Louisville, KY
#24 Parke-Davis, Morris Plains, NJ
#63,64 Pfizer Labs, Grover
#75 Physicians Health Plan, St. Louis
#45 Professional Healthcare Consultants, Jefferson City
#32 Professional Medical Management, Ballwin
#10 RCA Mutual Insurance Company, Springfield
#41 Reed & Carnick, Piscataway, NJ
#74 Roerig, St. Charles
#44 Rusk Rehabilitation Center, Columbia
#11 Sandoz Pharmaceuticals, E. Hanover, NJ
#29 Schering Corporation, Columbia
#62 Scott AFB/USAF, Creve Coeur
#3 Searle, Clarksville
#16 Sedgwick James, Clayton
#88 SmithKline Beecham Pharm., St. Louis
#40 Southern Medical Association, Birmingham, AL
#38 Southtown Medical Supply, Inc., St. Louis
#85 Southwestern Bell Mobile Systems, St. Louis
#30 Syntex Labs, St. Louis
#34 US Air Force Reserve, Dobbins AFB, GA
#42 USAF Recruiting, Columbia
#13 Versyss, Inc., St. Louis
#43 Wallace Laboratories, Cranbury, NJ
#27 WB Saunders, St. Charles
#26 Whitby Pharmaceuticals, Inc., Richmond, VA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■ **David Goldring, M.D.,** St. Louis, died May 26, 1992, at age 78. He received his medical degree at Washington University and became an instructor in the school's department of pediatrics in 1940. From 1950 to 1981, he headed the school's division of pediatric cardiology. From 1964 to 1976, he directed the pediatrics department. Dr. Goldring founded the pediatric cardiology service at the medical school and was a leader in research to define the causes of high blood pressure in children. He also helped to build a heart-lung machine in 1956 for Children's Hospital, the first pediatric hospital in the country to use the device to enable surgeons to correct congenital heart defects. In 1991, Dr. Goldring became the first recipient of the distinguished service award at Children's Hospital where he had been on staff for more than 40 years. He served the medical school as a professor emeritus until his death. He was director of the Missouri Rheumatic Fever Program from 1949 to 1955; secretary-treasurer of the American Pediatric Society; and president of the St. Louis Pediatric Society. He was a member of the board of directors of the American Heart Association and the St. Louis chapter of the Heart Association. He was also a member of the American Academy of Pediatrics, the Central Society for Clinical Research, the American College of Cardiology, and the American Pediatric Society. An endowment fund for studies of congenital heart disease at the medical school will be established and a diagnostic center under construction at Children's Hospital will be named in Dr. Goldring's memory.

■ **Carl G. Harford, M.D.,** St. Louis, Missouri, died May 18, 1992, at age 85. Dr. Harford received his medical degree at Washington University in 1933. He served as a researcher at the Rockefeller Institute, New York City, NY, in the late 1930s. He later joined the faculty at Washington University Medical School. Dr. Harford had been a pioneer in the study of viruses. He assisted in the development of antibiotic therapy and worked to evaluate penicillin in the 1940s. Dr. Harford was a member of the Central Society for Clinical Research, the American Society for Clinical Investigation, the Association of American Physicians, and the Infectious Diseases Society of America.

■ **Karl L. Keffler, M.D.,** St. Louis, Missouri, died May 17, 1992, at age 82. Dr. Keffler received his medical degree at St. Louis University School of Medicine, in 1935. He practiced family medicine in St. Louis more than 50 years. Dr. Keffler served as chief of staff at St. Joseph's Hospital in the early 1960s. He was a member of the American Academy of Family Physicians.

■ **John A. Virant, M.D.,** St. Louis, Missouri, died May 31, 1992, at age 86. Born in Lorain, Ohio, Dr. Virant received his medical degree at St. Louis University School of Medicine in 1931. He was an Otolaryngologist in St. Louis for more than 50 years. More than 30 of those years, he was on staff at DePaul Health Center. Dr. Virant also taught at St. Louis University School of Medicine. He was a member of the American Academy of Ophthalmology and Otolaryngology.

■ **James W. Willoughby, M.D.,** Liberty, Missouri, died May 27, 1992, at age 69. Dr. Willoughby received his medical degree at Washington University, in 1947. He practiced general medicine in Liberty from 1948 to 1954 and had an allergy practice there for 29 years. He had been president and laboratory director of Antigen Laboratories Inc. and laboratory director of the Clinical Immunology and Allergy Diagnostic Laboratory since 1976. He was on staff at Research, Baptist, North Kansas City and Liberty hospitals. He lectured at the University of Missouri-Kansas City School of Medicine and was president and chief medical director of the Missouri Postgraduate Course in Allergy. He was president of the Pan American Allergey Society; first president and past executive secretary of the Missouri State Allergy Association; past president of the Clay County Medical Society; former member of the Federation of State and Medical Boards; past secretary-treasurer of the Missouri State Board of Medical Examiners; and was a diplomate and former board member of the American Academy of Family Physicians. He directed a one-year allergy fellowship for American Academy of Otolaryngic Allergy. He was a fellow of the American Academy of Clinical Immunology and Allergy and the American Academy of Environmental Medicine. He was a member of the American Medical Association, Missouri State Medical Association, the American Academy of Allergy, the American College of Allergy and Immunology, the American College of Physicians, the Greater Kansas City Allergy Society, the Missouri State Allergy Association and the International Union of Immunological Societies. He received awards from the American Academy of Ophthalmology and Otolaryngology, the American Academy of Environmental Medicine, the American Rhinologic Society and the American Academy of Otolaryngic Allergy.

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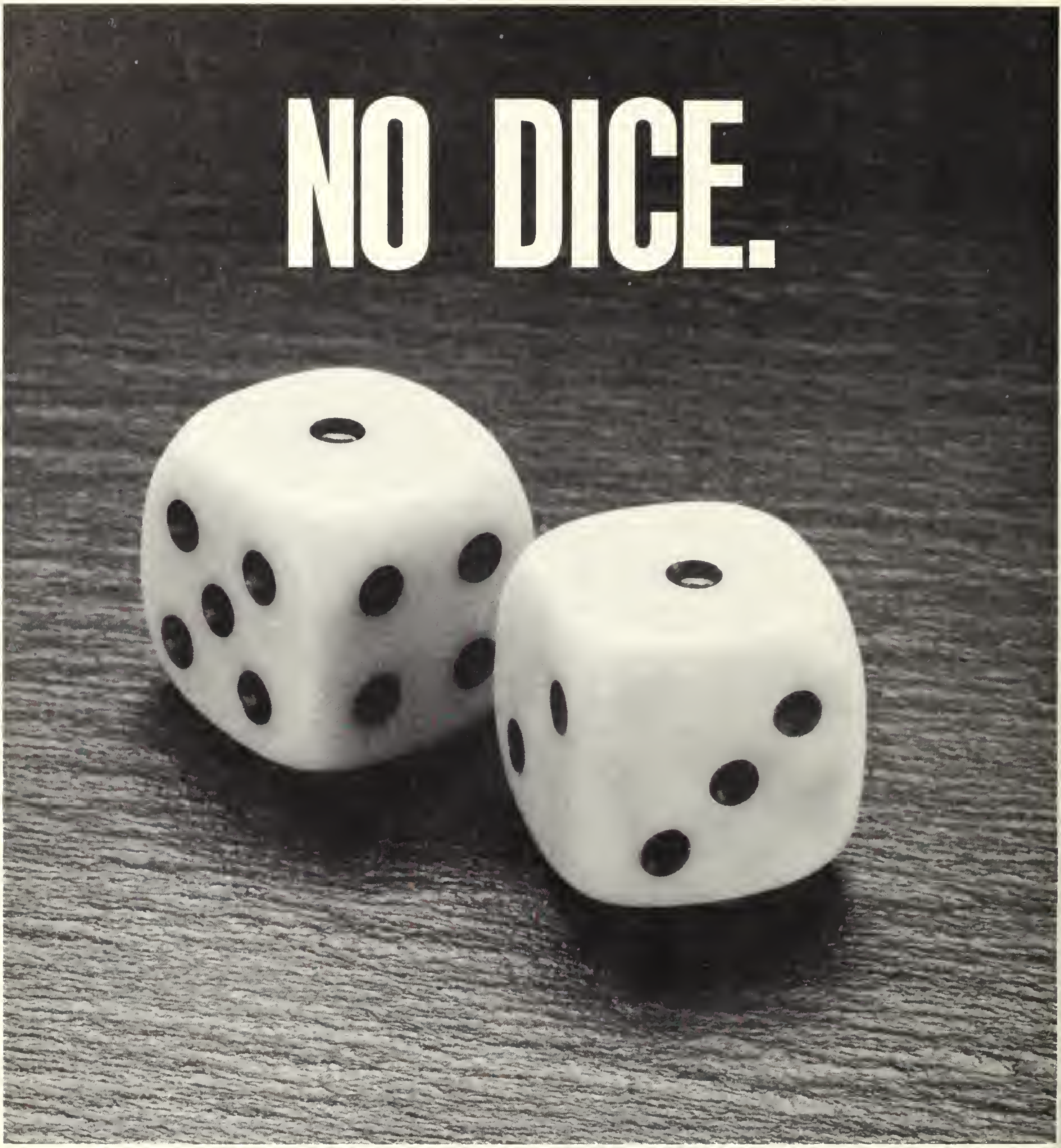

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INDEX TO ADVERTISERS

Air Force	454
Army	390
Berlin-Wheeler	448
Centerville Township Hospital	406
Eli Lilly & Co.	412
Hannibal Clinic	406
HealthCare Administrative Services	448
Healthcare Management Consulting	410
Jackson & Coker	402
Medical Defense Associates	392
Medical Protective Company	452
MOMEDICO	386
MonetaMed	388
Palisades Pharmaceuticals	424
PIE Mutual Insurance Co.	455
Postgraduate Medicine	402
Protective Life Insurance	410
RCA Mutual Insurance	434
Searle	456
Sedgwick James of Missouri	440
Sherriff & Associates	406
Southwest Billing Service	454

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References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:13I-15I. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Printed by the Ovid Bell Press, Inc., Fulton, Missouri 65251.

CONTENTS

VOLUME 89, NUMBER 8

Missouri State Medical Association

1992 - 1993 Membership Directory

MSMA Officers, Councilors and AMA Delegates 463

Code of Medical Ethics and Fundamental Elements of the Patient-Physician Relationship 468

MSMA Policy Manual 1992 - 1993 471

MSMA Constitution & Bylaws (revised April 1992) 477

1992 Super PAC Members 485

1992 MMPAC Sustaining Members 487

MSMA Committees and Commissions 493

Directory of Medical Specialty Organizations 495

MSMA Component Society Executives and Key Contact Person 499

Insurance Options for MSMA Members 503

State map with District and Component Society Boundaries 504

Guide to Districts, Councilors, Medical Societies & Code Numbers, and Counties Served 505

Members listed in Alphabetical Order 506

Component Medical Society List & Codes 506

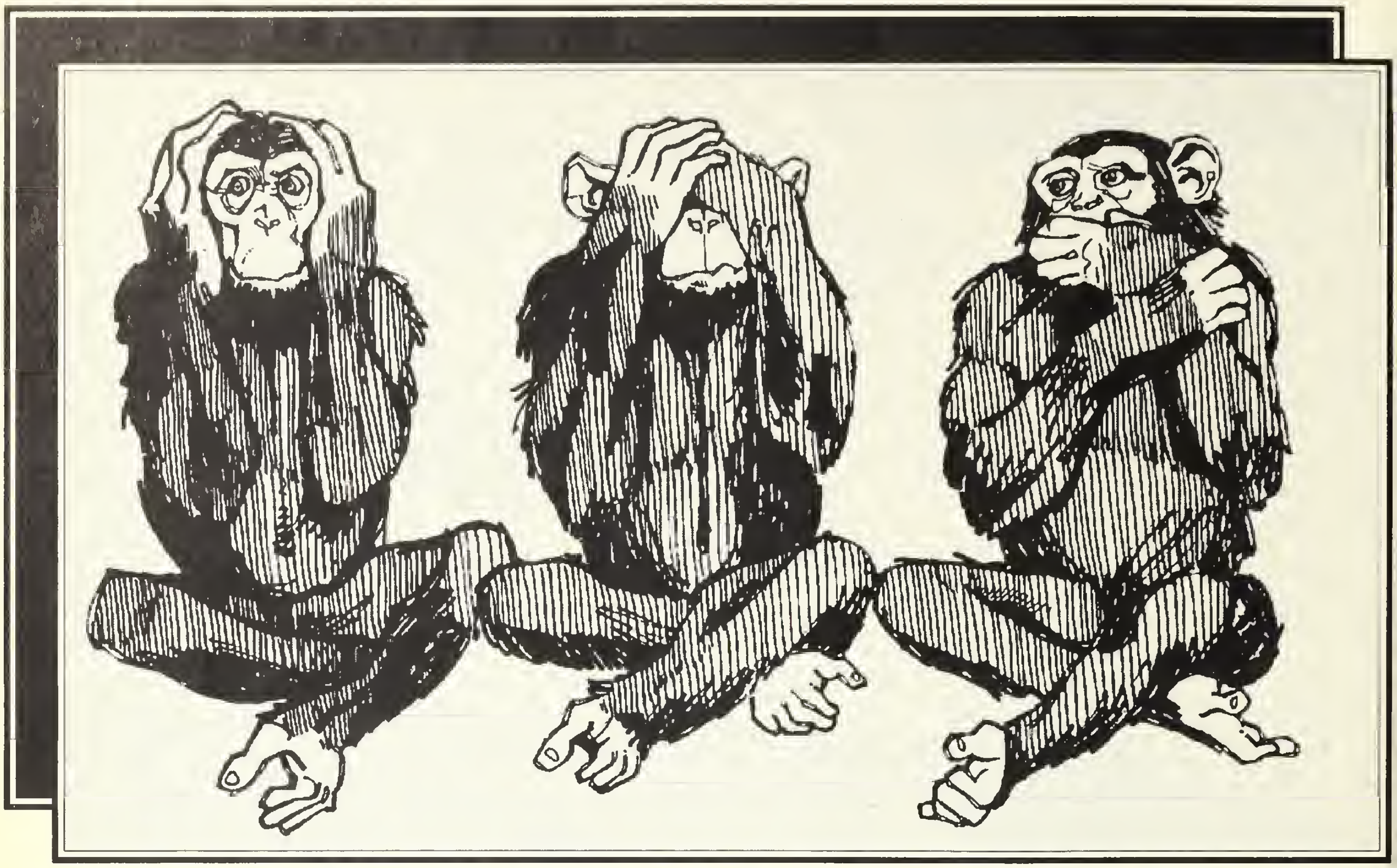
Codes for Self-Designation of Practice Specialties by Specialty 543

Members Listed by Specialty 544

Members Listed by Component Society 570

Information for Contributors 640

Classified Advertisements 641



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Vol. 89, No. 8 August 1992

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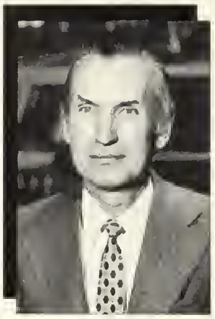
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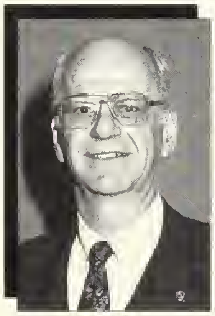
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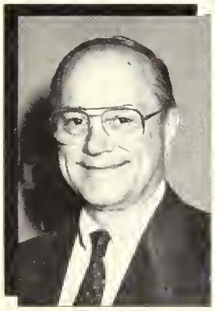
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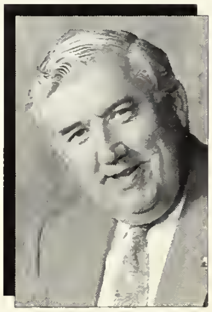
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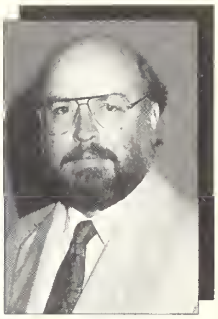

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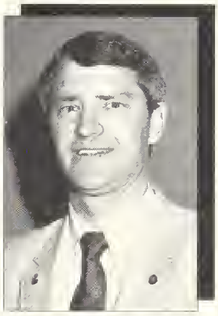

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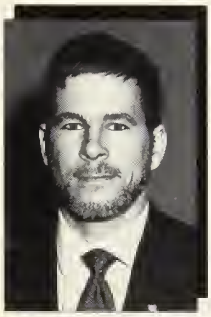

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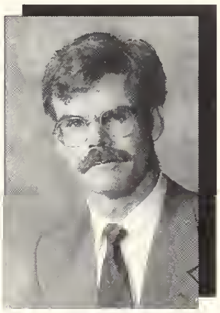

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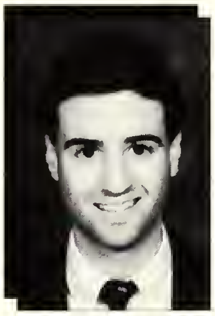

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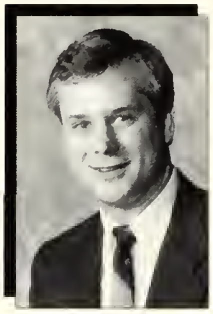

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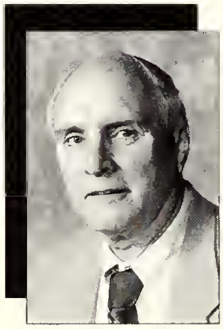

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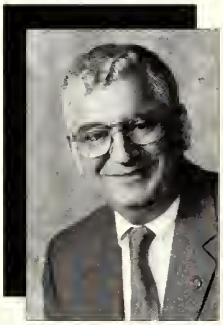

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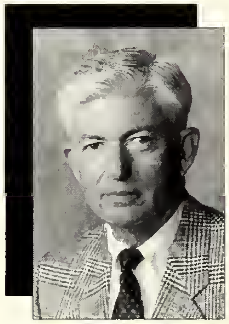

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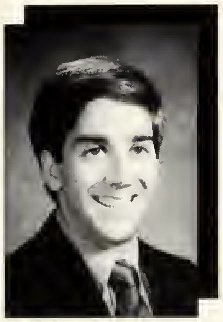

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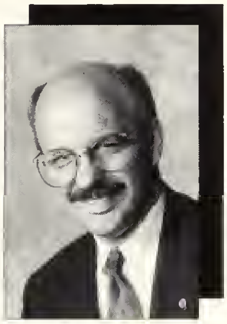

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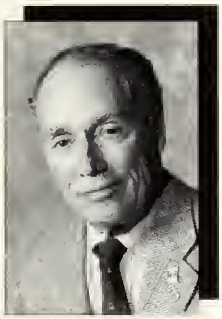

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Code of Medical Ethics and Fundamental Elements of the Patient-Physician Relationship

from the Council on Ethical and Judicial Affairs of the American Medical Association

HISTORY. The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him or her. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in Western Civilization as an expression of ideal conduct for the physician.

The most significant contribution to Western medical ethical history subsequent to Hippocrates was made by Thomas Percival, an English physician, philosopher, and writer. In 1803, he published his Code of Medictal Ethics. His personality, his interest in sociological matters, and his close association with the Manchester Infirmary led to the preparation of a "scheme of professional conduct relative to hospitals and other charities" from which he drafted the code which bears his name.

At the first official meeting of the American Medical Association at Philadelphia in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirurgical Society of Baltimore had formal written codes of medical ethics prior to this time, it is clear the AMA's first adopted Code of Ethics was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflect the temper of the times and the eternal quest to express basic concepts with clarity. Major revisions did occur in 1903, 1912, and 1947.

In December 1955, an attempt was made to distinguish medical ethics from matters of etiquette. A draft of a two-part code seeking to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a separation of then existing statements found in the Principles into two categories. Little or no change was made in the language of the forty-eight sections of the Principles.

Subsequently, in June 1956, a seemingly radical proposal was submitted to the House of Delegates for consideration. This proposal, a short version of the Principles, was discussed at the December 1956 session of the House after wide publication and broad consideration among members of the medical profession. It was postponed for final consideration until the June of 1957 meeting of the House of Delegates, when the short version was adopted.

The format of the Principles adopted in June 1957 is a change from the format of the Principles promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, "succinctly express the fundamental concepts embodied in the present (1955) Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June 1957 report that "every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification in particular selection of basic concepts has been eliminated."

In 1977, the Judicial Council recommended to the House of Delegates that the AMA Principles of Medical Ethics be revised to clarify and update the language, to eliminate reference to gender, and to seek a proper and reasonable balance between professional standards and contemporary legal standards in our changing society. Given the desire of the Judicial Council for a new version of the Principles to be widely accepted and accurately understood, in 1978 the Judicial Council recommended that a special committee of the House be appointed to consider such a revision. This was done in 1980, and the House of Delegates adopted the revision of the AMA Principles of Medical Ethics.

In June 1985, the Judicial Council became the Council on Ethical and Judicial Affairs.

PRINCIPLES OF MEDICAL ETHICS

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standard of conduct which define the essentials of honorable behavior for the physician.

I.

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II.

A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III.

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV.

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V.

A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI.

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII.

A physician shall recognize a responsibility to participate in activities contributing to an improved community.

FUNDAMENTAL ELEMENTS OF THE PATIENT-PHYSICIAN RELATIONSHIP

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

1.

The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2.

The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3.

The patient has the right of courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4

The patient has the right to confidentiality. The physician should not reveal confidential communications or information with out the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5.

The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.

6.

The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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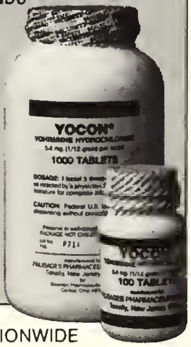

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1992 - 1993 Policy Manual

Alcohol Abuse

The MSMA continues to support the work of community-based organizations such as AA, Al-Anon, Narcotics Anonymous, and others, and it reaffirms its support of professional and public education efforts designed to alert people to the dangers of alcohol and drug abuse. In addition, the MSMA continues to support the Physician Rehabilitation Program and similar programs aimed at helping the victims of alcohol and drug abuse to recover successfully. (1987)

Board of Healing Arts

The MSMA opposes any legislation that would dilute the licensing power of the State Board of Registration for the Healing Arts to license physicians of good ethical and moral character. (1975)
The MSMA encourages and supports legislation directed toward developing a system of checks and balances with regard to the Board of Registration for the Healing Arts' ability to both investigate and assess (tax) physicians. (1992)

Cancer, Reporting

The MSMA supports efforts to require hospitals to report to the state all malignant neoplasms, with the exception of non-melanomatous cutaneous malignancies. These statistical data are necessary to determine relationships between cancer control efforts and the incidence of cancer in the state. (1982)

Chelation Therapy

The MSMA supports the use of IV chelation therapy in FDA-approved applications only. (1990)

Chiropractic

The MSMA is unaware of any scientific evidence that proves that spinal manipulation and adjustment are appropriate treatments for such health conditions as hypertension, heart disease, stroke, cancer, diabetes, and infection. (1981)

Definition of Death

A person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he has experienced a total and irreversible cessation of spontaneous brain functions, including the brain stem. Death shall have occurred at the time when the relevant functions ceased. (1987)

Diagnostic Tests, Ordering Of

With the exception of not-for-profit health fairs and mammography screening, the MSMA is opposed to, and considers unethical, the practice of ordering laboratory studies and other diagnostic tests without evidence or indication obtained by a physician in a history and physical examination. (1989; amended 1991)

Dioxin

The MSMA supports continuing monitoring of dioxin research, recognizing that to date no serious human disease has been conclusively linked to exposure to the chemical. The findings of the AMA Council on Scientific Affairs Panel on Toxic Substances are supported by the MSMA. (1985)

Drugs, Generic Prescribing

The MSMA opposes any interference into the practice of medicine by any governmental agency, third party payer, or commercial dispensing organization through mandated generic or therapeutic substitutions for physician prescriptions. (1992)

Drugs, Physician Dispensing

The MSMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA's published ethical guidelines. (1988)

The MSMA believes that dispensing of drugs and medical devices is part of the practice of medicine and that physicians always have the right to dispense needed drugs and devices. (1991)

Drugs, Therapeutic Substitution

The MSMA opposes the therapeutic substitution of prescribed medications. (1990)

Drunken Driving

The MSMA supports the development of local task forces to study and remedy the problem of drunken driving. These task forces should include physicians, prosecutors, law enforcement officers, and legislators. (1990)

Education, Loans for Medical Students

The MSMA supports continued federal and state subsidized, low-interest loan programs for medical students, with properly enforced repayment. (1982)

Education, School Health

Factual, academically founded courses should be developed and implemented by the Missouri Department of Education to teach human physiology and pathophysiology at the elementary and secondary levels of the school system. (1974)

County medical societies are urged to work with local school districts to assist in providing comprehensive health education programs, and the state colleges of Missouri are urged to prepare qualified health instructors trained to integrate health concepts into all the courses they teach. (1972)

Emergency Care

The MSMA supports the American College of Emergency Physicians and the American College of Surgeons standards for direct medical control of pre-hospital (emergency) care by qualified physicians. (1986)

Ethics, Education in Medical School

The MSMA supports the teaching of medical ethics to medical students and resident physicians, including information on the workings of professional disciplinary agencies. (1987)

Expert Witness Qualifications

The MSMA supports legislation to formalize required qualifications for physicians wishing to testify as expert witnesses.(1992)

Fee-for-service Medicine

The MSMA believes that the traditional American fee-for-service medical system should be given equal consideration and equal treatment under the law as other systems of health care provision. (1990)

Fee Splitting

The MSMA reaffirms its support of the AMA Judicial Council's position that the acceptance of financial consideration in exchange for patient referrals, or fee splitting, is unethical and improper. (1985)

Fireworks

The MSMA supports legislation to prohibit the sale of Class C fireworks in the state of Missouri. (1991)

Fluoridation

The MSMA, realizing the medical importance of naturally occurring fluoride taken in proper concentration into the human body, recommends the addition of fluoride to all drinking water systems in Missouri in the concentration of one part per million. (1972)

Foreign Medical Graduates

The MSMA Council and committees are encouraged to consult with Foreign Medical Graduate groups when subjects of interest come up. All physicians, foreign medical graduates included, are encouraged to participate in their component medical societies, the MSMA, and the AMA. (1982)

Governmental Intrusion into Practice of Medicine

The MSMA opposes any further governmental intrusion into the practice of medicine, particularly in the form of rules and regulations from federal agencies. (1992)

Handicapped

The MSMA is involved in seeking positive ways to encourage training and rehabilitation for disabled persons. The MSMA wants to work with existing organizations to remove physical and emotional barriers that prevent people from working. (1982)

Health Care Costs

The MSMA encourages individual physicians to do their part in helping moderate increases in health care costs by avoiding overutilization and by using restraint when considering fee increases, in order to keep them in line with general cost of practice increases. (1989)

Helmets, Use of

The MSMA urges all motorcyclists to wear protective head gear (helmets) to prevent death and disability. (1977)

The MSMA supports legislation requiring the use of bicycle safety helmets as an effective method of reducing death and injury. (1991)

Hospital Medical Staffs, Autonomy

Since the hospital medical staff is a largely autonomous entity within the hospital, the MSMA supports the securing of separate legal counsel by medical staff members when considering matters of rules, regulations and bylaws. (1985)

Hospital Medical Staffs, Membership

The hospital medical staff cannot be forced to accept for full voting membership any member of the allied health professions. This is in keeping with the MSMA's support of existing JCAHO and AMA guidelines that state no hospital governing board can unilaterally amend the bylaws of a self-governing medical staff, nor can it unreasonably withhold approval of the bylaws. (1987)

The MSMA supports existing state statutes and regulations that delineate requirements for hospital licensure and individual eligibility for medical staff privileges. (1989)

Human Rights

The MSMA continues to support the dignity of the individual, the importance of human rights and the sanctity of human life, and continues to oppose any discrimination based on an individual's ethnic origin, religious or political beliefs, or any such reprehensible policies. (1986)

Immunization

The MSMA supports American Academy of Pediatrics guidelines for immunization of children. (1987)

Indigent Care

The MSMA urges all physicians to share in the care of indigent patients. (1988)

Insurance, Charge for Extra Claim Forms

Physicians should feel free to charge for the additional service of filing more than one insurance claims form for an individual patient, especially if different claim forms are required rather than a photocopy of the original form. (1973)

Insurance, Insurance Company Communications

The MSMA urges health insurance companies to cease to communicate abusive and inappropriate language to patients regarding their physicians' fee structures and services. (1985)

Insurance, Maternity Coverage

The MSMA supports inclusion in all insurance policies for those in childbearing years of a clause providing complete maternity coverage.

In order to provide continuity of coverage, the following eligibility period should be written into all insurance policies concerning benefits for obstetric care: "A pregnancy which begins while the insurance is in force should be covered until the termination of the puerperium and until the newborn infant is discharged from the hospital to home care." (1974)

Insurance, New Waiting Periods

The MSMA believes employees should not have to undergo a new waiting period for coverage of pre-existing illness whenever their employer changes insurance companies, particularly when the change is being made in the interest of controlling health care coverage costs. (1985)

Insurance, Psychiatric Illnesses

The MSMA recommends that the state require all health and accident insurance policies sold in Missouri to provide coverage for psychiatric illnesses equivalent to benefits for other medical and physical illnesses. (1978) Reaffirmed (1985)

Insurance, Right to Know

The MSMA encourages all third party payors to provide an easily understood explanation of their benefits and coverage to their policyholders. (1986)

Laboratory, Collecting Fee

The MSMA supports payment under Medicaid to the physician for his service in collecting a specimen for tests performed in an outside laboratory. (1977)

Licensing, Federal

The MSMA opposes any moves to require federal licensure of health manpower. (1976)

Malpractice, Countersuits

Any Missouri physician found not to be negligent in a malpractice suit shall have the assistance of the MSMA in determining if there exists a reasonable basis for the physician to commence an action for malicious prosecution arising out of such case. (1976)

Mandated Second Opinion

The MSMA suggests that the physician who renders a mandated second opinion for a proposed surgical procedure not accept that person as a patient for the proposed surgical procedure. (1987)

Mandatory Assignment

The MSMA is opposed to mandatory assignment under Medicare. (1984)

The MSMA is opposed to the withholding of medical licensure based on the physician's non-acceptance of Medicare assignment. (1987)

Medical Examiner System

The establishment of a county medical examiner system as a replacement for the county coroner system is strongly recommended. (1971)

Medicare-Mandated Restrictions

The MSMA opposes Medicare-mandated restrictions on any laboratory tests, referrals, medical examinations or any financial arrangements that might be agreed upon between physician and patient. (1988)

Medicare - DRGs for Physician Reimbursement

The MSMA opposes the use of Diagnosis-Related Groups as a system of reimbursing physicians under the Medicare program. (1992)

Medicare - Reimbursement to Starting Physicians

The MSMA believes starting physicians should not be reimbursed at a lower rate than other physicians.

All physicians should be reimbursed equally for equal services. (1992)

Medicare - Single Statewide Payment Factor

The MSMA supports the adoption by the Health Care Financing Administration of a single, statewide geographic Medicare physician payment adjustment factor for the state of Missouri. (1992)

Medicare - Third Party Reimbursement, Physicians

The MSMA supports equal reimbursement for equal professional services provided by a physician, regardless of his geographic location. (1982) Reaffirmed (1987)

Medicare - Reimbursement, Hospital DRGs

The MSMA believes it is unfair for Medicare to grant a lower payment to rural hospitals, as compared to urban hospitals, for patient care under the same DRG. (1988) Reaffirmed (1989)

Mentally Incompetent Patients, Hospitalization

The MSMA urges extension of the time limit from 7 to 21 days before the family of a mentally incompetent patient must petition the court for continuation of a hospitalization. (1985)

MSMF Loans

The Missouri State Medical Foundation requires membership in the state medical association for those medical students eligible for membership and receiving assistance from the Foundation. (1980)

Nurse Practitioners

The MSMA supports the doctrine that physicians should retain control of medical care and will challenge any person who is practicing medicine without a license, in the courts of law if necessary. (1978)

Patient Accountability

The MSMA encourages government, at all levels and whenever possible, to incorporate incentives for patients to behave in ways not detrimental to their health. (1992)

Peer Review Organization Data

The MSMA asks that data from the Missouri Patient Care Review Foundation concerning decision-making criteria for Medicare admission be made available to Missouri physicians as a way to ensure that denials are not having a negative impact on the quality of medical care for these patients. (1985)

The MSMA supports the current AMA program of data collection on the costs of PRO implementation and the inequities in the PRO system. (1987)

Peer Review Organization Review

The MSMA reaffirms its belief that physicians' work should be reviewed only by other physicians. In addition, the MSMA supports the modification of PRO standards of reviewer anonymity, believing that the reviewers' work should also be subject to review. (1990)

Physician as Patient Advocate

The MSMA affirms its support of the physician in the role of patient advocate in the consumption of health care services, particularly when this role conflicts with the economic goals of the physician's employing third party. (1987)

Physician Assistants

The MSMA opposes state licensure or certification of additional health care personnel because there is no reason to accept a second class or second level of medicine. (1979)

Physician, Right to Choose

The MSMA supports the right of each physician to determine for him or herself whom he or she will or will not accept as patients and to exercise his or her choice by the terms of contractual agreements with other physicians, medical groups, third party payers, governmental agencies, hospitals or other institutions. (1981; updated 1992)

Physician, Right to Hospital Privileges

The MSMA is opposed to the granting of hospital privileges to a physician based on that physician's profitability to the hospital. (1988)

Political Process

The Association encourages physicians to become Key Contacts, thereby increasing medicine's role in influencing actions taken by the Missouri General Assembly on issues of importance to our patients and our profession. (1983)

Primary Medical Care

Primary medical care shall be defined as only that care given by a licensed graduate of a medical or osteopathic school. (1977)

Referral to Licensed Limited Practitioner

A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other licensed provider of health care services whenever the physician feels that these services will benefit the patient. As is the case with physician referrals, limited practitioner referrals should be based on the practitioner's individual competence and ability to perform service to the patient.(1981)

Registered Dietitians

The MSMA supports the concept that any person using the title "dietitian" should be a Registered Dietitian. (1987)

Health Care Decision-making, Right to Refuse Treatment

Believing that critical decisions should be left to the patient, the family, or health care surrogate, and not to the state, the MSMA opposes any legislation that would require court approval for the withdrawal of life support systems, including artifical hydration and nutrition. The MSMA opposes legislation that would impose an arbitrary waiting period before such life support could be withdrawn. (1990)

Health Care Decision-making, Surrogate Decision-maker

The MSMA supports legislation allowing competent Missourians to appoint a health care surrogate, empowered by the patient to make medical decisions for him if he be unable. Such authority should include the power to accept or refuse any and all medical treatment for the patient, including artificial nutrition and hydration. (1990)

Smoking

The MSMA supports legislation directed at designating non-smoking areas in public places, and prohibits smoking at all MSMA House of Delegates meetings and scientific sessions held in conjunction with these meetings. (1981)

The MSMA actively supports legislation prohibiting cigarette smoking in public indoor areas. (1983)

School Bus Safety

The MSMA endorses special pre-licensing examination and investigation of prospective school bus drivers in Missouri, according to criteria established by law. (1986)

Utilization Review, Reimbursement

In those hospitals that conduct utilization review of any inpatient care, compensation of physicians for such review is a legitimate expense. The cost of such review should be included in hospital rates and reimbursable costs regardless of the source of payment. (1976)

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Constitution & Bylaws of the Missouri State Medical Association

adopted 1903 (revised April 1992)

Constitution

Article I. Name of the Association

The name and title of this organization shall be the Missouri State Medical Association.

Article II. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

Article III. Membership

Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.

Article IV. House of Delegates

The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past-Presidents of the Association, the Speaker and Vice-Speaker and the Deans of each medical school located in Missouri who are members of the Missouri State Medical Association, who shall serve as Delegates-at-Large. Its Secretary shall be the Secretary of the Missouri State Medical Association.

Article V. Council

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the medical student component societies, the Resident Physicians Section, and the Hospital Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article VI. Council on Ethical and Judicial Affairs

The Council on Ethical and Judicial Affairs shall be the judicial body of the Association. It shall consist of five active members nominated by the President and elected by the House of Delegates.

Article VII. Sessions and Meetings

Section 1. The Association shall hold an annual Spring Convention of the House of Delegates, at places fixed by the House of Delegates, the time of which shall be fixed by the Council. During the Annual Convention, the House shall hold at least three sessions.

Section 2. Special meetings of the Association or the House of Delegates may be called by a two-thirds vote of the Council and shall be called upon a petition signed by members equal in number to one-third of the total number of delegates certified for the last Annual Convention.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates, and Councilors selected as provided for.

Section 2. The Officers shall be elected annually. The term of Councilors and Vice-Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor and hospital medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilors and Vice-Councilor from that district. The Delegates from the medical school component societies, the Resident Physicians Section and the Hospital Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice-Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Article IX. Funds, Expenses and Budget

Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates. The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

Article X. Referendum

At any General Meeting of the Association, it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the association shall determine the question.

Petitions signed by 10 percent of the active members of the Association, including petitioners representing at least one-half of the component medical societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

Article XI. Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XII. Amendments

The House of Delegates may amend any article of the constitution by a two-thirds vote of the delegates present and voting in any Annual Convention,provided that such amendment shall have been presented in the previous open meeting of the House of Delegates and that the amendment shall have been published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

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Bylaws

Chapter I. Membership

Section 1. Members of this Association shall be those individuals whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri, except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Section 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Section 3. There shall be five classes of members as follows:

Active members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Resident members shall be limited to those members of the Resident Physicians Section who are serving a full-time post-graduate training program in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Student members shall be limited to those members of component societies who are pursuing a course of study leading to the degree of Doctor of Medicine in a medical school approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Special Dues-Exempt members shall be limited to those members of component societies who have been elected to the U.S. Congress, the Missouri State Legislature, or to an office in the executive branch of the state or federal government. They shall be exempt from the payment of dues until the term of their political office expires, and shall enjoy all the privileges of active membership.

Chapter II. General Meetings

Section 1. The General Meetings shall be open to all registered members and guests.

Section 2. Any paper read before this Association shall be considered for publication in the Journal if the author so desires. Such papers may be given publication priority over regularly submitted papers but shall be subject to the same editorial review and selection policies.

Section 3. No person in the active practice of medicine in the State of Missouri shall appear on the program of the Association unless he or she is a member of the Missouri State Medical Association.

Chapter III. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Convention.

All resolutions received at the association office no later than 45 days prior to the opening session of the Annual Convention will be accepted as business of the House of Delegates and will be published in the Delegates Handbook. Any additional resolutions to be introduced at the opening session must be made available to each member of the House of Delegates at least 24 hours before the opening session. These will be accepted as business of the House at the opening session and will be referred to an appropriate Reference Committee. Resolutions introduced at the opening session, but which did not meet the 24-hour deadline, will be referred to a Reference Committee only if approved by two-thirds of the Delegates voting. Sufficient copies of the resolution, printed in standardized format, or funding for same, must be supplied by the individual or society introducing the resolution.

At the second session of the House of Delegates, introduction of Resolutions would be allowed only if approved by two-thirds of the delegates voting. The same procedure with regard to resolutions would be followed at the last session, but it would then take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Section 2. Delegates to the House of Delegates shall be allotted according to the following formula:

(a). Each component society shall be entitled to send each year one delegate or one alternate for each 25 full paid members or fraction thereof in the Association as of December 31 of the previous year.

(b). One additional delegate or alternate is allowed for each 100 members or major fraction thereof as of December 31 of the previous year.

(c). When a component society's full paid membership as of December 31 of the previous year reaches 1,000, that society shall be entitled to an additional 30 delegates or alternates.

(d). When a component society's full paid membership as of December 31 of the previous year reaches 2,000, that society shall be entitled to an additional 50 delegates or alternates.

(e). Each component society which is composed of two or more counties shall be entitled to at least one delegate from each of the counties having one or more member physicians practicing in the county of which the component society is composed; however, such delegates from multicounty component societies must practice or reside in the county they represent. Alternate delegates may be elected from the entire membership of the component medical societies.

(f). All Past-Presidents of the association, the Speaker and Vice-Speaker, and the deans of each medical school located in Missouri who are members of the Missouri State Medical Association shall serve as Delegates-at-Large.

(g). Only duly elected delegates have the privilege of the floor at meetings of the House of Delegates. However, any delegate may request the privilege of the floor for any other individual, which privilege may be granted or denied by the Speaker, subject to disapproval by a majority vote of the House of Delegates.

Section 3. Each Medical School Component Society shall be entitled to send each year two delegates, elected by the component society, to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the component society. Such student delegates shall enjoy all the rights and privileges of all other delegates.

Section 4. The Resident Physicians Section shall be entitled to send each year six delegates elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association. Such resident delegates shall enjoy all rights and privileges of all other delegates.

Section 5. The Hospital Medical Staff Section shall be entitled to send each year one delegate elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all rights and privileges of all other delegates.

Section 6. Forty delegates shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the association.

Section 7. From among members of the House of Delegates, the Speaker shall appoint reference committees to which reports and resolutions, on a majority vote of the House of Delegates, shall be referred as follows:

Reference Committee A
Reference Committee B
Reference Committee C
Reference Committee D
Reference Committee E

The Speaker may appoint such other reference committees as he may deem necessary, upon approval of the House of Delegates.

The President shall appoint a Committee on Credentials.

Section 8. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 9. The House of Delegates shall divide the state into Councilor Districts, specifying which counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component societies shall be members.

Section 10. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Section 11. The House of Delegates shall receive and act upon a complete detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component societies at least four weeks prior to the Annual Convention. These shall be published in the Journal.

Section 12. The following shall be the general order of business of the House of Delegates for the first session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Election of officers.
6. Reports of officers.
7. Reports of committees.
8. Unfinished business.
9. New business (Chap. III, Sec. 1).
10. Installation of officers.
11. President's appointments and installation of members to committees.
12. Selection of the place for the next Annual Convention.

At any session of the House of Delegates, the order of business may be changed by a two-thirds affirmative vote of the members present and voting.

Chapter IV. Election of Officers

Section 1. The President, on the first day of the Annual Convention, shall select a Committee on Nominations consisting of thirteen delegates, one from each Councilor District, one from a medical school component society, one from the Hospital Medical Staff Section and one from the Resident Physicians Section.

The Committee on Nominations shall determine that proposed candidates for office are qualified and willing to serve and shall report at the Second Session to the House of Delegates in the form of a ticket containing the names of one or more members for each of the officers listed in Article VIII of the Constitution, which are to be filled at the Annual Convention, excepting the Secretary and Treasurer, who are elected by the Council from the general membership.

Section 2. All contested elections shall be by written ballot. A majority of the votes cast shall be necessary to elect.

Delegates and Alternates for the American Medical Association shall be elected as follows:

The Nominating Committee shall propose one or more candidates for each delegate position for a full two-year term, one or more candidates for each alternate position for a full two-year term, and one or more names for each unexpired position.

When a nomination for AMA delegate term is contested, the AMA delegates shall be elected by ballot. Each MSMA delegate may have one vote for each delegate to be elected and each vote shall be cast for a different nominee. A nominee is elected if he receives votes on the majority of the ballots cast, and has the highest number of votes cast for that position. If all vacancies for AMA delegates are not filled on the first ballot, then subsequent ballots will be taken with the nominee receiving the fewest number of votes cast in each subsequent ballot dropping out of consideration on the next ballot and each MSMA delegate casting one vote for each position in each subsequent ballot until one nominee for each position is elected.

The election for AMA alternates and an election to fill an unexpired term will be conducted in the same manner.

In case no nominee for general offices of the Association (see Article VIII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected.

Section 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 4. Delegates present at the Annual Convention from Councilor Districts whose Councilors' and Vice-Councilor's terms expire shall hold meetings on or before the morning of the last day of the Annual Convention and elect Councilors and a Vice-Councilor for their district for a term of two years. The names of the elected Councilors and Vice-Councilors shall be given on prescribed forms to the Secretary for presentation to the House of Delegates. Each candidate for Councilor or Vice-Councilor must reside or practice in the district for which he is elected.

Section 5. Each Councilor District shall be entitled to one Councilor for each 400 full paid members or portion thereof and full paid members of the Resident Physicians Section training in that Councilor District as of December 31 of the preceding year. Each District shall be entitled to one Vice-Councilor.

Section 6. Delegates from the four Medical School Component Societies shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the medical student component societies shall serve on an annual renewable basis.

Section 7. Delegates from the Resident Physicians Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Resident Physicians Section shall serve on an annual renewable basis.

Section 8. The Hospital Medical Staff Section shall combine and elect one Councilor and one Vice-Councilor. The duly elected Councilor and Vice-Councilor from the Hospital Medical Staff Section shall serve on an annual renewable basis.

Section 9. The Speaker and Vice-Speaker shall not serve more than three consecutive terms.

Section 10. The Speaker shall appoint a parliamentarian to serve as such during the sessions of the House of Delegates at each Annual Convention and upon whom the Speaker may call before deciding points of order or procedure.

Chapter V. Duties of Officers

Section 1. The **President**, or his designated representative, shall preside at scientific sessions of the Association. He shall preside at the House of Delegates in the absence of the Speaker or Vice-Speaker and until their successors are elected. He shall appoint all committees not otherwise provided for. He shall deliver an annual address at such times as may be arranged and shall perform such other duties as custom or parliamentary usage requires. He shall be the real head of the profession of the state and assist the Councilors in building up the component societies and in making their work more practical and useful.

Section 2. The **President** and the **President-Elect** shall be members of the Council and shall attend all meetings of the Council. The President-Elect shall assume the office of the President at the Annual Convention following his election to the position of President-Elect. Should the office of President-Elect become vacant through death or otherwise, the Council may fill the vacancy by appointment until the next Annual Convention.

Section 3. The **Vice-Presidents** shall assist the President in the discharge of his duties. Prior to the meeting of the Nominating Committee, the President-Elect shall recommend to the Nominating Committee the name of a member to serve as First Vice-President. In the event of the death, resignation, or removal of the President, the First Vice-President shall serve as President for the unexpired term.

Section 4. The **Treasurer** shall give bond in the sum of $50,000. He shall demand and receive all funds due the Association, together with bequests and donations. Money shall be paid out of the treasury only on the written order of the President and Executive Vice-President, the President and Treasurer, or the Treasurer and Executive Vice-President. The Treasurer shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his actions and of the state of the funds in his hands.

Section 5. The **Secretary** shall attend the General Meeting of the Association and the sessions of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and shall keep a record of its proceedings. He shall be the custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association that come into his hands. He shall provide for the registration of the members and delegates at the Annual Convention. He shall, with the cooperation of the secretaries of the component societies, keep a register of all the legal practitioners of the state by counties, noting on each his status in relation to his component society,and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their reports and shall collect from them the regular per capita dues and assessments and turn the same over to the Treasurer.

Chapter VI. Council

Section 1. The Council shall meet during the Annual Convention and at such times as necessity may require, subject to the call of the Chairman or on petition of three Councilors. It shall meet on the last day of the Annual Convention to organize. The Council shall elect a Chairman and a Vice-Chairman for a term of one year. The Chairman may be reelected to serve not more than four consecutive terms of one year each. The Council shall, through its Chairman, make an annual report to the House of Delegates.

Section 2. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the condition of the profession, and to keep in touch with the activities of and aid in the betterment of the component societies of his district. He shall make reports of his work and the condition of the profession of each county in his district to the Council. The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed on a properly itemized statement submitted monthly and within the current year, including his expense in attending the Annual Convention of the Association. No Councilor shall be eligible for the position of Delegate to the House of Delegates during his term of office as councilor, nor shall he vote in the House of Delegates.

Section 3. The Council shall be the executive body of the Association and between the Annual Conventions shall exercise the power conferred on it by the House of Delegates under the Constitution and Bylaws.

Section 4. Charters shall be issued to component societies only on approval of the Council and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 5. In sparsely settled sections, the Council shall have authority to organize the members of two or more counties into societies, to be suitably designed so as to distinguish them from district societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 6. The Council shall provide for and supervise the issuance of all publications of the

Association including proceedings, the transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component societies as provided in Chapter III, Section 11. The Council shall submit an annual report to the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Section 7. The Council shall appoint, at least six months prior to the Annual Convention, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Convention. On recommendation of the Committee, the Council shall appoint a Chairman of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Convention is to be held, and who shall appoint and organize from the members of the component society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall serve as host for the Annual Convention and shall also act in an advisory capacity for the staff of the Executive Vice-President of the Association, who is responsible for arrangements for the Annual Convention.

Section 8. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Conventions of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

Section 9. The salaries of all employees of the Association shall be fixed by the Council.

Section 10. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Section 11. The Council shall be empowered to elect an Executive Vice-President and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

Chapter VII. Committees and Commissions

Section 1. Standing Committees of the Missouri State Medical Association, the chairmen of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Physicians Health Committee.

The **Executive Committee** shall consist of the Association President, the Immediate Past President, President-Elect, Secretary, Treasurer, Council Chairman and Council Vice-Chairman. The President of the Association shall be Chairman of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Vice-President's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient and bring before the House of Delegates such amendments as it or other members of the Association may present for consideration. The President shall appoint one member for one year, two members for two years and two members for three years. As the term of each expires, his successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of five members and be appointed annually by the Council and shall be responsible for general publication and distribution policies of the Journal. The editor of the Journal shall be designated by the Council and also shall serve as Chairman of the Committee on Publication. The Editor shall be empowered to nominate an Editorial Board, subject to approval by the Council. The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material for publication in the Journal.

The Committee on **Legislative Affairs** shall consist of five members of the Association, appointed annually by the President. The Committee shall consider legislative proposals affecting health problems of the people of the state and the practice of medicine and shall make recommendations to the Council and the House of Delegates as well as directing staff activities in such matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two members shall be appointed for one year, two for two years, two for three years, two for four years and two for five years. As the term of each expires, his successor shall be appointed for a term of five years. In making such appointments, the President shall be governed by experience of the member, the size of his medical society and his geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one-third to one-half of the committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The **Physicians Health Committee** shall consist of members of the Association appointed by the President for a term of three years. The Physicians Health Committee shall plan and execute programs of professional assistance for members of this Association who may require assistance to continue or return to their professional activities.

Section 2. Standing Commissions of the Missouri State Medical Association, who shall be responsible to the Council and whose chairmen shall be appointed by the Association President, will be as follows:

Commission on Public Affairs.
Commission on Medical Economics, Third Party Medicine and Governmental Relations.
Commission on Continuing Education and Health Manpower.
Commission on Medical-Legal Affairs.
Commission on Interspecialty Medicine.

Subsec. a. The standing commissions, unless otherwise provided in these Bylaws, shall consist of fifteen members serving three-year terms and the terms will be staggered so that the President will appoint five members of each Commission each year. Initially, the President will appoint five members to one-year terms, five members to two-year terms and five members to three-year terms and no member shall serve more than two consecutive terms.

Subsec. b. The chairman of each Commission may appoint Ad Hoc Committees to carry out the Commission's programs. These Ad Hoc committees may include any Missouri State Medical Association member.

Subsec. c. The Chairman of the Council shall appoint each year an appropriate Councilor to serve as advisor to each respective Commission.

The Commission on **Public Affairs** shall plan and execute programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense and other public matters.

The Commission on **Medical Economics, Third Party Medicine and Governmental Relations** shall keep close liaison and work with peer and utilization review mechanisms, insurance intermediaries and governmental agencies.

The Commission on **Continuing Education and Health Manpower** shall determine the character and scope of the scientific proceedings of the Association for each Annual Convention as well as to make all arrangements for such Annual Convention, subject to the instructions of the House of Delegates. The Commission shall also be responsible for the entire continuing education program of the Association, shall have all matters pertaining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in professional as well as in allied health fields and shall be responsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall investigate and study medical-legal matters affecting the practice of medicine, make recommendations to the Council and House of Delegates and also make certain that all Association members are kept informed of important developments in this field. The Commission also may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with governmental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to him by the specialty organization. In the event that such a nominee is not submitted to him by an organization, the Association President may designate a member of the specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socioeconomic and legislative matters that affect their particular specialties; in addition, the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Section 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constitute a quorum.

Section 4. Special committees may be appointed by the President or the Council as circumstances may demand.

Chapter VIII. Hospital Medical Staff Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also members of a hospital medical staff in a Missouri hospital, and who are selected by the physician members of their respective medical staffs.

Section 2. Governing Council. There shall be a Governing Council of the Hospital Medical Staff Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chairman. The Chairman shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chairman. The Vice Chairman shall assist the Chairman and preside in the absence of the Chairman or at his/her request.

(d). Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Delegates and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 7. Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Hospital Medical Staff Section. The representative must be an MSMA member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the medical staff.

Only duly selected representatives to the Hospital Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the MSMA. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the MSMA Council.

Section 8. Purposes of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the business meeting prior to the Annual Convention of the MSMA House of Delegates a Chairman, Vice Chairman, Secretary-Treasurer, Delegate and Alternate Delegate.

(e). To conduct such other business as may properly come
before the meeting.

Chapter IX. Resident Physicians Section

Section 1. Membership. The Resident Physicians Section shall be composed of Resident Members of the Missouri State Medical Association who are serving in approved training programs.

(a). Governing Council. There shall be a Governing Council for the Resident Physicians Section. The Governing Council shall consist of the officers of the Resident Physicians Section and two members-at-large of the Section. All members of the Governing Council must be Resident Physician members of the Missouri State Medical Association elected by the members attending the Business Meeting of the Resident Physicians Section.

1. Duties. The Governing Council shall direct the programs and the activities of the Resi-

dent Physicians Section.

2. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident Physicians Section.

Section 2. Officers. The Members attending the Business Meeting of the Resident Physicians Section shall elect the following officers, who shall have these duties and responsibilities:

(a). Chairman. The Chairman shall preside at all meetings of the Governing Council and the Business Meetings of the Resident Physicians Section.

(b). Vice Chairman. The Vice Chairman shall preside at meetings of the Governing Council or the Business Meetings of the Resident Physicians Section, in the absence of the Chairman or at the request of the Chairman.

(c). Secretary. The Secretary shall maintain such records as are required or advisable for the conduct of the activities of the Resident Physician Section.

(d). Delegates and Alternate Delegates. The Delegates and Alternate Delegates shall represent the Section in the MSMA House of Delegates.

Section 3. Business Meeting. There shall be a Business Meeting of members of the Resident Physicians Section. The Business Meeting shall be held on a day prior to each Annual Meeting of the House of Delegates.

Section 4. Rules of Order. Only members of the Resident Physicians Section shall have the right to vote, but the meetings shall be open to any members of the Missouri State Medical Association. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council.

Section 5. Purposes of the Meeting. The Purpose of the meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To elect a Chairman, who shall serve until the conclusion of the next Annual Meeting.

(c). To elect other officers of the Resident Physicians Section and two members-at-large of the Governing Council. Those elected shall assume office at the conclusion of the Annual Meeting at which they are elected and shall serve until the conclusion of the next Annual Meeting.

(d). To consider and vote upon such matters as may properly come before the meeting.

Chapter X. Dues and Assessments

Section 1. (a). The annual dues of this Association shall be $300, which shall be applicable to each active member of the Association beginning in 1987 and shall be levied per capita on the active members of the component societies; physicians leaving training programs and entering practice for the first time shall be assessed dues of $150 for the first calendar year and shall be Active members; physicians entering their second year of practice shall be assessed dues of $225 for the calendar year and shall be Active members; the per capita levy for resident members shall be $20 per year; student members shall be assessed dues of $5 per year; honor members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Those members who join after July 1 of any given year shall be assessed at one-half of their regular dues rate, outlined in this section, for the calendar year in which they join.

Section 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Section 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active, resident and student member. Such assessment shall be levied only by consent of two-thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessment shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for reallocation.

Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Upon authorization of any component society, the Treasurer of this Association may collect the per capita levies directly from the members of that component society. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his name is properly reported and his dues for the current year are paid. On December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an Annual Convention.

Chapter XI. Rules of Conduct

Section 1. The ethical principle governing the members of the American Medical Association shall govern members of this Association.

Section 2. Any member of this Association who testifies as a medical expert witness outside of the specialty of the physician represents unethical conduct. In the future, any physician who testifies as a medical expert witness outside of his specialty or logical extension of his field of expertise or who interferes with the proper administration of justice by misrepresenting his qualifications or giving false or misleading testimony will be subject to expulsion, censorship, or reprimand after due process from the Missouri State Medical Association.

Any member of this Association who testifies as a medical expert witness without meeting the qualifications set forth in this section, shall be subject to expulsion, censorship, or reprimand after a due process hearing as set forth. An expert witness must have basic educational and professional knowledge as a general foundation for his testimony and, in addition, have current personal experience and practical familiarity with the problems being considered and be actively engaged in the practice of the medical subject under discussion.

Nothing in the above is to be construed as preventing the treating physician from testifying on the merits of the case.

Chapter XII. Rules of Order

The deliberations of this Association shall be conducted in accordance with usages as defined in *Sturgis Standard Code of Parliamentary Procedure.*

Chapter XIII. Component Societies

Section 1. All component societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Section 2. Each component society shall be judge of the qualifications of its members, subject to review and final decision by the Council on Ethical and Judicial Affairs of the State Association. Every reputable and legally qualified physician or medical student who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council on Ethical and Judicial Affairs of the State Association shall have final authority to expel a member should a component society fail to do so after being so requested by the Council on Ethical and Judicial Affairs.

The Council, may upon request of a component society, remit the state dues and assessment of a member who has become totally and permanently incapacitated through mental or physical disability and has been a member in good standing during the three consecutive years immediately preceding his disability; provided that the component society shall remit the component society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member found to fall within what is classified as a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the component society dues of such member.

A physician living near a component society boundary line may hold his membership in that component society most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

Section 3. Any member who may feel aggrieved by the action of the component society in suspending or expelling him shall have the right to appeal to the Council on Ethical and Judicial Affairs, whose decision shall be final. A component society shall at all times be permitted to appeal or refer questions involving membership to the Council on Ethical and Judicial Affairs of the State Association for final determination.

Section 4. In hearing appeals, the Council on Ethical and Judicial Affairs may admit oral or written evidence or both as in its judgment will most fairly present the facts.

Section 5. When a member in good standing in a component society moves to another jurisdiction in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the jurisdiction to which he moves. Pending his acceptance or rejection by the component society to which he moves, such member shall be considered to be in good standing in the component society from which he was certified and in the State Association to the end of the period for which his dues have been paid.

A member of a component society who moves to and engages in the practice of medicine at a location in another area in which there is a component society shall forfeit his membership in this Association and the Secretary shall remove his name from the roster of members of the Missouri State Medical Association unless within one year after such change of residence he becomes a member of the component society of the area to which he has moved.

Section 6. Each component society shall have general direction of the affairs of the profession in its area and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician and medical student in the area. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician and medical student in the area.

Section 7. At some meeting in advance of the Annual Convention of this Association, each component society, the Hospital Medical Staff Section, and the Resident Physicians Section shall elect one or more delegates and an equal number of alternates to represent it in the House of Delegates of this Association, in accordance with Chapter III, Section 2, 3, 4, or 5 of these Bylaws. The Secretary of each component society, the Hospital Medical Staff Section and the Resident Physicians Section shall send a list of such delegates and alternates to the Secretary of this Association at least sixty days before the Annual Convention. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Section 8. The secretary of each component society shall keep a roster of its members and, if practicable, a list of non-affiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He shall send a copy of the program of each meeting to his district Councilor and to the Secretary of the State Association.

Section 9. Any component society, in a manner approved by the State Association, or the State Association with the consent of the component society affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low-income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships shall be and remain as though it were strictly an individual employment.

Chapter XIV. Council on Ethical and Judicial Affairs

Section 1. The Council on Ethical and Judicial Affairs shall have original jurisdiction in all questions involving Missouri State Medical Association membership, all controversies arising under the Constitution and Bylaws and under the rules of conduct as outlined in the Bylaws, and controversies between two or more component societies or their members. The Council on Ethical and Judicial Affairs shall be the judicial authority of the Missouri State Medical Association and its decisions shall be final. The Council on Ethical and Judicial Affairs shall also investigate general ethical conditions and matters pertaining to the relations of physicians to one another or to the public and make recommendations to the House of Delegates or the component societies.

Section 2. The Council on Ethical and Judicial Affairs shall be composed of five members elected to five-year terms. Nominees shall be submitted by the President for election by the House of Delegates. Any vacancy occurring on the Council on Ethical and Judicial Affairs shall be filled by nomination of the President and election by the House at its next Convention for the remainder of the unexpired term. The first five members of the Council on Ethical and Judicial Affairs shall be elected on a staggered basis; one for one year, one for two years, one for three years, one for four years, and one for five years.

Section 3. The Council on Ethical and Judicial Affairs shall select a Chairman and Vice Chairman and it may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs, subject to approval by the MSMA Council.

Chapter XV. Amendments

Section 1. These Bylaws may be amended at any Annual Convention by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has lain on the table for one day.

Section 2. Upon the adoption of this Constitution and these Bylaws, all previous constitutions and bylaws are thereby repealed.

Chapter XVI. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

❑ ❑ ❑

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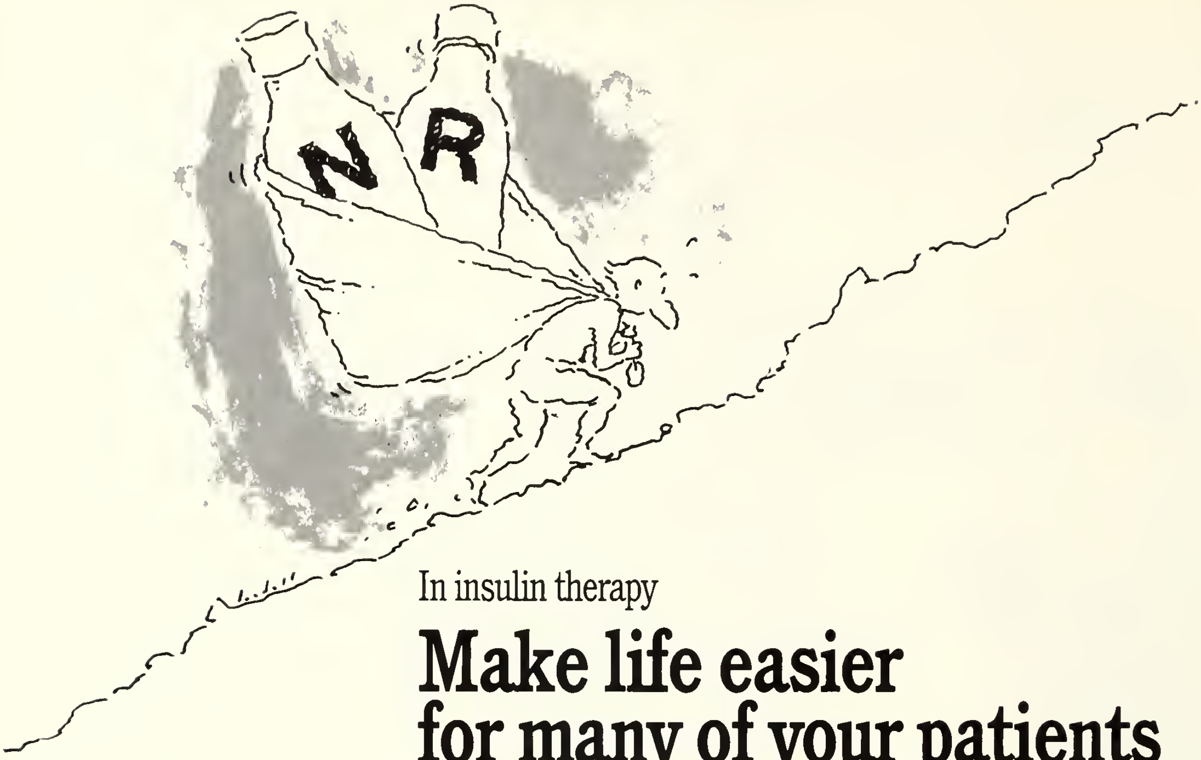

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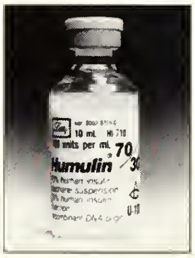

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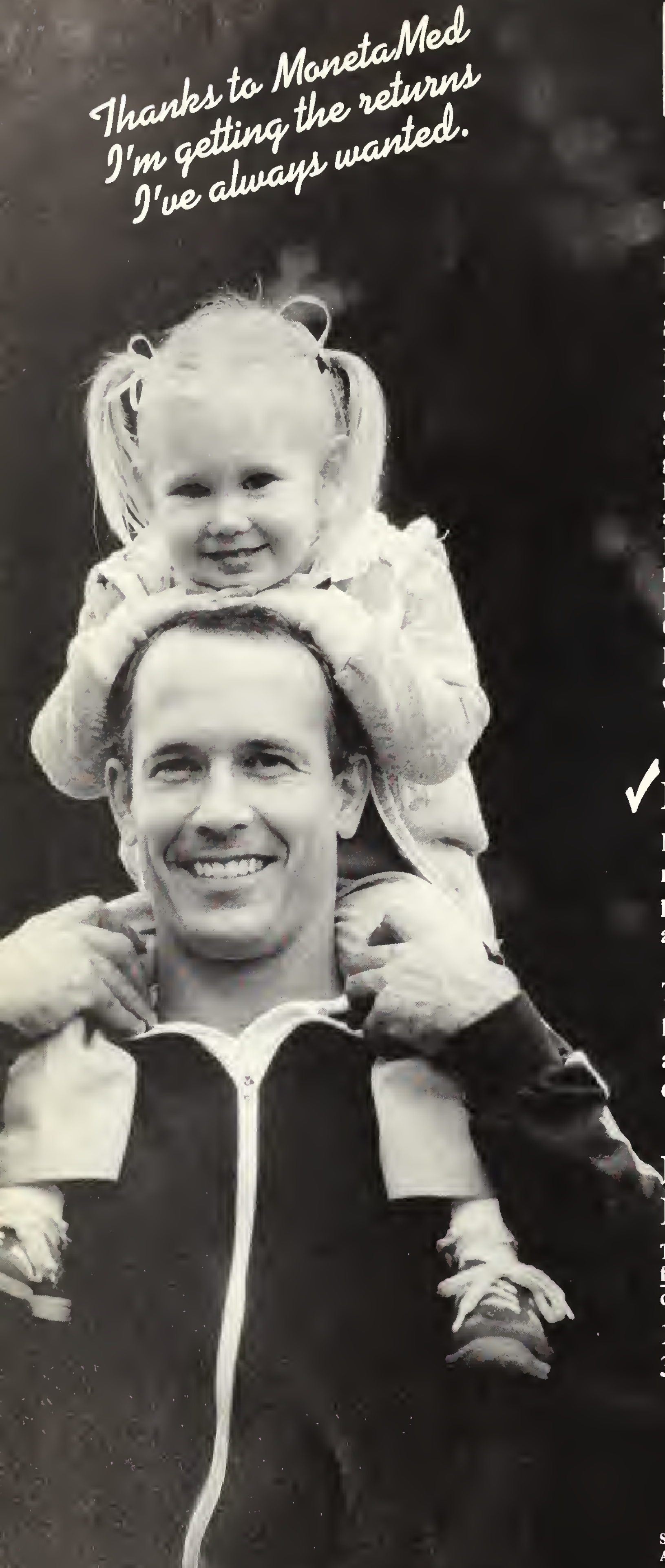

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MONETAMED PROFILE

THOMAS P. DOYLE, M.D.

HOME: St. Louis, Missouri

AGE: 36.

SPECIALTY: Orthopedic Surgery.

MEDICAL COLLEGE: University of Missouri, 1978

PRACTICE: "I recently purchased an established but declining sole practitioner office from a retiring physician. It's a risk, but they say that great deeds are usually wrought at great risk."

HOBBIES: Horseback riding and golf. "If I combined activities, would it be polo?"

LAST BOOK READ: Missouri: Images of Nature, photographed by Charles Gurche.

LATEST ACCOMPLISHMENT: "Testing a protective knee pad I'm developing for use by football players."

PROFILE: Independent and open-minded. "Living in the country, I don't feel hampered by social convention. I can work on new ways of doing things."

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* * *

Directory of Medical Specialty Organizations

Specialty	President	Next Meeting Date
Missouri State Allergy Association	Michele E. Kemp, MD 1585 Woodlake Drive #201 Chesterfield, MO 63017 (314)636-5151	MSMA Annual Convention, April 1- 4, 1993 Tan-Tar-A Resort, Lake of the Ozarks
Greater Kansas City Allergy Association	Michael L. Loren, M.D. 17500 Medical Center Parkway, Suite 6 Independence, MO 64057 (816)478-1500	Quarterly meetings, One Annual Meeting
Missouri Society of Anesthesiologists	Bruce Weaver, D.O. PO Box 7041 Columbia, MO 65201 (314)636-6905	MSMA Annual Convention, April 1 - 4, 1993 Tan-Tar-A Resort, Lake of the Ozarks
Greater Kansas City Society of Anesthesiologists	Richard L. Morgan, M.D. Saint Joseph Health Center Dept. of Anesthesiology 1000 Carondelet Drive Kansas City, MO 64114 (816)943-2251	TBA
St. Louis Society of Anesthesiologists	Sidney J. Bennett, M.D. 1 Barnes Hospital Plaza, Box 8054 St. Louis, MO 63110 (314)362-6973	TBA
St. Louis Cardiac Club	Alan J. Tiefenbrunn, M.D. 2120 Madison Ave. Granite City, IL 62040 (618)876-2700	TBA
St. Louis Society of Colon and Rectal Surgery	Anthony M. Vernava, III, M.D. 800 E. Northwest Hwy, Suite 1080 Palatine, IL 60067 (700)359-9184	May 2-7, 1993, Hyatt Regency, Chicago, IL
Crohn's & Colitis Foundation of America	Teri Pollard, RPH 8900 State Line, Suite 354 Leawood, KS 66206 (913)648-7738	Executive Committee meets first Tuesday every month, Board meets June & December
Kansas City Dermatologic Society	Holly Fritch Kirby, M.D. 4601 W. 19th St., Suite 106 Overland Park, KS 66211 (913)451-3030	Third Thursday every month
St. Louis Dermatological Society	David B. Marrs, M.D. 330 First Capitol Drive, Suite 460 St. Charles, MO 63301 (314)946-7608	Fall meeting - October 20 Other meetings to be announced
The St. Louis Ear, Nose and Throat Club	Gerald W. Moritz, M.D. 522 N. New Ballas Rd. St. Louis, MO 63131 (314)432-4110	Third Wednesday of January, March, May & November
Missouri Chapter, American College of Emergency Physicians	Michael Szewczyk, M.D. 910 West Broadway Columbia, MO 64068 (314)636-2144	April 3, 1993 - MSMA Annual Convention
Emergency Physicians Medicine Foundation	Laura S. Fitzmaurice, M.D. Children's Mercy Hospital 24th & Gillham Road Kansas City, MO 64108 (816)234-3897	TBA
Missouri Academy of Family Physicians	David Glover, M.D. 220 E. Culton Warrensburg, MO 64093 (816)747-5114	MSMA Annual Convention, April 1 - 4, 1993 Tan-Tar-A Resort, Lake of the Ozarks

Kansas City Academy of Family Practice	Michael Munger, M.D. P.O. Box 5308 Kansas City, MO 64131 (816)763-5200	Second Wednesday each month
St. Louis Academy of Family Physicians	Gary P. Lessmann, M.D. 106 Four Seasons Bldg., Suite 104A Chesterfield, MO (314)434-3144	Sept. 19 - Fall Symposium, Adam's Mark Nov. 14 - Scientific Session, Ritz-Carlton Nov. 20 - Annual Meeting, Bogey Club
St. Louis Gastrointestinal Endoscopy Society	Burton A. Schatz, M.D. 3009 N. New Ballas Rd. St. Louis, MO 63131 (314)432-1111	TBA
Kansas City Gynecological Society	Richard H. Sinclair, M.D. 7920 Ward Parkway, Suite 205 Shawnee Mission, KS 66204 (816)523-3383	Third Thursday of January, March & May
St. Louis Gynecological Society	Tom M. Yazdi, M.D. 9147 Watson Rd. St. Louis, MO 63110 (314)963-1040	Quarterly (October, January, March and May)
Missouri Society of Internal Medicine	David Fleming, M.D. 1513 Union St. Moberly, MO 65270 (816)263-4040	MSMA Annual Meeting, April 1-4 Tan-Tar-A Resort, Lake of the Ozarks
St. Louis Society of Internal Medicine	Leon Robison, M.D. 222 S. Woods Mill Rd., Suite 750 N Chesterfield, MO 63126 (314)275-8600	Monthly meetings to be announced
Greater Kansas City Society of Internists	J. Simon Szeto, M.D. 720 Oak, Suite 200 Kansas City, MO 64106 (816)471-2892	Quarterly (February, April, September & November)
Missouri Chapter, American College of International Physicians	Ramesh Khanna, M.D. 2514 Ridgefield Rd. Columbia, MO 65203 (314)882-7991	TBA
Missouri State Neurological Association	William J. Crowley, Jr., M.D. 111B E. Walnut Columbia, MO 65203 (314)874-8985	MSMA Annual Meeting, April 1-4 Tan-Tar-A Resort, Lake of the Ozarks
Kansas City Neurology & Neuro Surgery Society	Michael E. Ryan, M.D. 8800 W. 75th St., Suite 100 Shawnee Mission, KS (913)384-4200	TBA
St. Louis Society for Neurological Sciences	Robert L. Grubb, M.D. 3635 Vista at Grand St. Louis, MO 63110 (314)362-3567	Quarterly
Missouri Section, American College of OB-GYN (ACOG)	Stephen Gordon, M.D. 930 Carondelet Dr., Suite 304 Kansas City, MO 64114 (816)943-2229	MSMA Annual Meeting, April 1-4 Tan-Tar-A Resort, Lake of the Ozarks
Great Plains College Occupational & Environmental Medicine	Commander Richard J. Miller, M.D. 601 E. 12th St., Room 907 Kansas City, MO 64106 (816)426-3433	Meets as scheduled
St. Louis Society of Medical Oncology	Alex E. Denes, M.D. 330 First Capitol Drive St. Charles, MO 63301 (314)947-4007	TBA
Missouri Ophthalmological Society, Inc.	Stephen Slocum, M.D. 1034 S. Brentwood, #694 St. Louis, MO 63117 (314)636-5098	MSMA Annual Meeting, April 1-4 Tan-Tar-A Resort, Lake of the Ozarks
Kansas City Society of Ophthalmology & Otolaryngology	Jacquelyne Holdcraft, M.D. 3036 Gillham Rd. Kansas City, MO 64108 (816)531-8432	Four times a year

St. Louis Ophthalmological Society	Alan Tess, M.D. Suite 17413 E. Pavilion St. Louis, MO 63110 (314)367-1181	September 17, October 22, November 19 January 28, February 25, March 25 & April 27 University Club Building
Missouri State Orthopaedic Association	Joseph Sudekum, M.D. 621 S. New Ballas Rd., #53 St. Louis, MO 63141 (314)636-5151	MSMA Annual Convention, April 1-4, 1993 Tan-Tar-A Resort, Lake of the Ozarks
Kansas City Orthopaedic Society	Roger P. Jackson, M.D. 2750 Clay Edwards Dr., Suite 600 N. Kansas City, MO 64106 (816)471-6611	Four times a year
St. Louis Orthopedic Society	James C. Strickland, M.D. 6400 Clayton Rd., Suite 302 St. Louis, MO 63117 (314)647-8562	October 28, Other meetings to be announced
Jackson County Osteopathic Society	Richard E. Ogden, D.O. 400 E. Red Bridge Rd., Suite 105 Kansas City, MO 64131 (816)942-5397	January, April, September, December - Third Tuesday of each month
Missouri Society of Otolaryngology - Head & Neck Surgery	John Ellis, M.D. 14480 E. 42nd St. Independence, MO 64055 (314)636-5151	MSMA Annual Convention, April 1-4, 1993 Tan-Tar-A Resort, Lake of the Ozarks
Missouri Society of Pathologists	Gordon Johnson, M.D. Jefferson Memorial Hospital Festus, MO 63028 (314)933-1620	MSMA Annual Convention, April 1-4, 1993 Tan-Tar-A Resort, Lake of the Ozarks
Mid-Missouri Pathology Society	Ann Havey, M.D. Health Sciences Center Columbia, MO 65212 (314)882-8154	TBA
Kansas City Society of Pathologists	Peter K. Shireman, M.D. Providence-St. Margaret Health Center 8929 Parallel Parkway Kansas City, KS 66112 (816)596-4722	First Wednesday, September - May
St. Louis Pathological Society	Christine M. Janney, M.D. 615 S. New Ballas Rd. St. Louis, MO 63141 (314)569-6120	Three times a year (Spring, Summer & Fall) TBA
Missouri Chapter, American Academy of Pediatrics	Robert Edmonds, M.D. 111B East Walnut Columbia, MO 65203 (314)874-8985	TBA
Greater Kansas City Pediatric Society	Joachim R. Brill, M.D. 7920 Ward Parkway, Suite 205 Kansas City, MO 64114 (816)523-3383	First Wednesday of each month
St. Louis Pediatric Society	Sandra S. Dodson, M.D. St. Luke's Hospital 226 S. Woods Mill Rd., Suite 33W Chesterfield, MO (314)542-4897	TBA
Physical Medicine and Rehabilitation	Otakar Machek, M.D. 6744 Clayton Rd. St. Louis, MO 63117 (314)645-6606	MSMA Annual Convention, April 1-4, 1993 Tan-Tar-A Resort, Lake of the Ozarks
St. Louis Society of Physical Medicine & Rehabilitation	Martin B. Wice, M.D. 615 S. New Ballas Rd. St. Louis, MO 63141 (314)569-6436	Next meeting - August 13 Meet Quarterly
Missouri Association of Plastic & Reconstructive Surgeons	William B. Webber, M.D. 6400 Clayton #110 St. Louis, MO 63117 (314)645-6051	MSMA Annual Convention, April 1-4, 1993 Tan-Tar-A Resort, Lake of the Ozarks
Plastic Surgery Society of Kansas City	Thomas E. Geraghty, M.D. 3036 Gillham Rd. Kansas City, MO 64108 (816)756-1132	Bimonthly, Third Tuesday - January, March, May, September & November

St. Louis Area Society of Plastic Surgery	Meredith J. Payne, M.D. 222 S. Woods Mill Rd., Suite 700 Chesterfield, MO 63017 (314)878-7770	October & January
Eastern Missouri Psychiatric Society	Lori DeRosear, D.O. 4940 Children's Place St. Louis, MO 63110 (314)362-2465	TBA
Central Missouri Psychiatric Association	S. Jay Lensgraf, M.D. #3 Hospital Drive Columbia, MO 65201 (314)636-5151	MSMA Annual Convention, April 1-4, 1992 Tan-Tar-A Resort, Lake of the Ozarks
Western Missouri Psychiatric Society	Jack Edminsten, M.D. 3036 Gillham Rd. Kansas City, MO 64108 (816)531-8432	Quarterly
Missouri Radiological Society	Stephen Phillips, M.D. 1502 E. Broadway Columbia, MO 65201 (314)443-4591	TBA
Greater Kansas City Radiological Society	James P. Anthony, M.D. 1010 Carondelet Dr., Suite 114 Kansas City, MO 64114 (816)942-6900	Second Wednesday, January - April, October & November
Greater St. Louis Society of Radiologists	Thomas E. Reh, M.D. 6420 Clayton Rd. St. Louis, MO 63117 (314)362-8566	Oct. 20 - Carman Lecture
St. Louis Rheumatology Association	Benjamin D. Schwartz, M.D. 6651 Chippewa, Suite 301 St. Louis, MO 63109 (314)644-4411	September, November, March & May
Missouri Chapter, American College of Surgeons	Michael Bukstein, M.D. P.O. Box 311 Hannibal, MO 63401 (417)869-5222	April 3, 1992 - MSMA Annual Convention Annual Meeting, June 18-20, 1993
Missouri State Surgical Society	Joseph Corrado, M.D. 809 Medical Park Drive, #103 Mexico, MO 65265 (314)636-5151	MSMA Annual Convention, April 1-4, 1992 Tan-Tar-A Resort, Lake of the Ozarks
Kansas City Surgical Society	Joseph A. Pinkerton, Jr., M.D. 4320 Wornall Road, Suite 308 Kansas City, MO 64111 (816)753-7460	Quarterly, third Wednesday
St. Louis Surgical Society	Philip L. Robbins, M.D. 621 S. New Ballas Rd. St. Louis, MO 63141 (314)569-6656	November 3 - St. Louis Metro Medical Society November 16 - Executive Committee Mtg. January 19 - Annual Meeting
Missouri Thoracic Society	Dennis R. Pyszcyynski, M.D. UMKC School of Medicine 2411 Holmes St. Kansas City, MO 63108 (816)235-1978	MSMA Annual Convention, April 1-4, 1992 Tan-Tar-A Resort, Lake of the Ozarks
St. Louis Thoracic Surgical Society	John P. Marbarger, M.D. 3635 Vista Ave. at Grand St. Louis, MO 63110 (314)577-8360	December & May TBA
Missouri Urological Society	Michael Chehval, M.D. 621 S. New Ballas Rd., #6002 St. Louis, MO 63141 (314)991-2626	MSMA Annual Convention, April 1-4, 1992 Tan-Tar-A Resort, Lake of the Ozarks
Kansas City Urological Society	Mark Noble, M.D. University of Kansas Medical Center 39th & Rainbow Blvd. Kansas City, MO 66103 (913)588-6148	Third Wednesday, Sept - May (excluding Dec.)
St. Louis Urological Society	David Hardy, M.D. 1031 Bellevue, Suite 280 St. Louis, MO 63117 (314)645-6454	Twice a year, Spring & Fall

MSMA Component Societies Executives

Andrew County Medical Society
J.L. Villahermosa, M.D., Sec.
803 Highway 71 West
Savannah, MO 64485

Audrian County Medical Society
Harry B. Cohen, M.D., Sec.
P.O. Box 598
Mexico, MO 65265

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Carolyn Depriest, Exec. Sec.
P.O. Box 3986
Poplar Bluff, MO 63901
314/686-3171

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1204 Gulf Street
Lamar, MO 64759

Boone Cooper-Howard) County Medical Society and
Cole (Moniteau-Osage) County Medical Society
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111-B East Walnut
Columbia, MO 65203
314/874-8985

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801 Faraon
St. Joseph, MO 64501
816/271-7517

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1 Flower Lane Terrace
Moberly, MO 65270

Callaway County Medical Society
Vernon Jackson, M.D., Sec.
808 Center St. Suite 202
Fulton, MO 65251

Cape Girardeau County Area Medical Society
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1005 N. Kingshighway
Cape Girardeau, MO 63701
314/334-5691

Clay-Platte Medical Society
Darren Frerking, Exec. Director
3036 Gillham Road
Kansas City, MO 64108
816/531-8432

Clinton County Medical Society
Larry Ozenberger, M.D., Sec.
400 Clay
Plattsburg, MO 64477

D-H-P-D County Medical Society
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1125 North Butterfield Rd.
Bolivar, MO 65613

Dunklin County Medical Society
Nicholas F. Robinson, M.D., Sec.
501 Teaco Road
Kennett, MO 63857

F-G-W County Medical Society
Philip Dean, M.D., Sec.
800 East 5th St.
Washington, MO 63090

Grand River Medical Society
Myoung Soo Keay, M.D., Sec.
103 Eleventh
Chillicothe, MO 64601

Greene County Medical Soceity
James Thompson, Jr., Exec. V.P.
1200 E. Woodhurst Bldg., D-200
spingfield, MO 65804
417/887-1017

Henry County Medical Society
Kenneth F. Scott, M.D., Sec.
Medical Building Hospital Drive
Clinton, MO 64096

Jasper County Medical Society
Judy Miller, Exec. Director
P.O. Box 2424
Joplin, MO 64803
417/624-3920

Jefferson County Medical Society
Alfred D. Shaplin, M.D., Sec.
0.5Sam J. Byland, M.D., Sec.
120 Hudson Street
Wellsville, MO 63384

Johnson County Medical Society
Curtis Dyer, M.D., Sec.
222 E. Culton Street
Warrensburg, MO 64093

Lafayette-Ray County Medical Society
Robert R. Pavlu, M.D., Sec.
Waverly Clinic
Waverly, MO 64096

Lake of the Ozarks Medical Society
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Camdenton, MO 65020

Metropolitan Medical Society of Greater Kansas City
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3036 Gillham Road
Kansas City, MO 64108
816/531-8432

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Rolla, MO 65401

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2902 North Baltimore
Kirksville, MO 63501

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Hannibal, MO

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Neosho, MO 64850

Pemiscot County Medical Society
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Hayti, MO 63851

Perry-Ste. Genevieve Medical Society
Niranjana Raju, M.D., Sec.
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Ste. Genevieve, MO 63670

Pettis County Medical Society
Rodney Hartman, M.D., Trea.
1735 Sycamore, Rt. 3
Sedalia, MO 65301

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Louisian, MO 63353

St. Charles-Lincoln County Medical Society
Deonna Randall, Exec. Sec.
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St. Charles, MO 63301
314/925-0411

St. Louis Metropolitan Medical Society
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3839 Lindell Blvd.
St. Louis, MO 63108
314/371-5225

Saline County Medical Society
Douglas Koehn, M.D., Sec.
913 Redwing Drive
Marshall, MO 65340

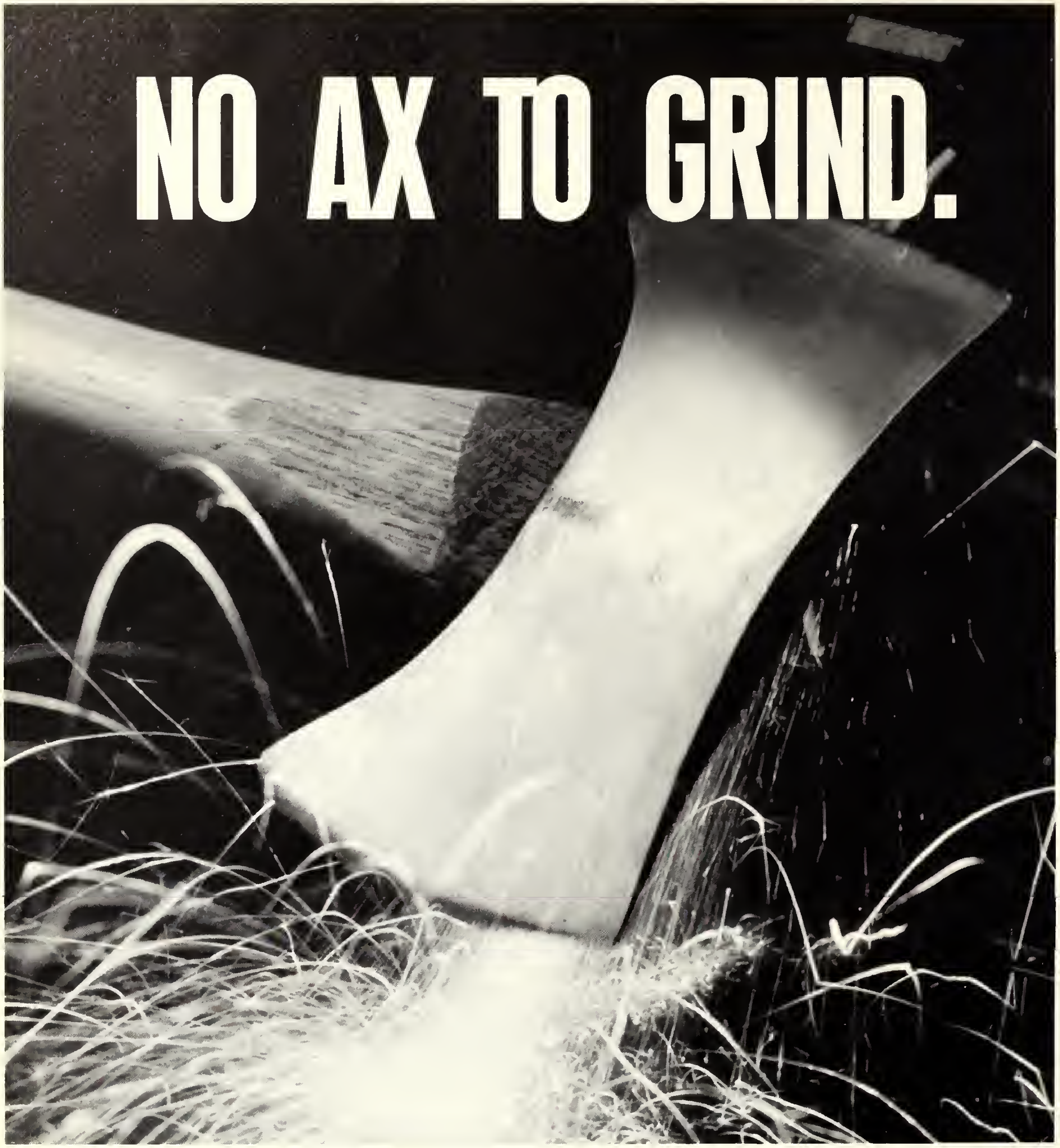
SEMO Medical Society
Ted Roberts, M.D., Sec.
1118 North Main Suite B
Sikeston, MO 63801

South Central Medical Society
Thomas R. Stubbs, M.D., Sec.
709 Kentucky
West Plains, MO 65775

Tri-Lakes Medical Society
Richard D. Loveland, D.O., Sec.
H.C.R. #1, Box 282
Hollister, MO 65672

Webster County Medical Society
Robert Bareis, M.D., Sec.
Rt. #1, Box 2645
Marshfield, MO 65706

West Central Medical Society
Raphael Torontow, M.D., Sec.
Rt. # 2
Nevada, MO 64772



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Omaha Mid-West Clinical Society

60th Annual Postgraduate Assembly

November 5, 6 & 7, 1992

Red Lion Hotel
Omaha, Nebraska

For Information Contact:

Lorraine Seibel
Omaha Mid-West Clinical Society
7389 Pacific Street, Suite 229
Omaha, Nebraska 68114
(402) 397-1443

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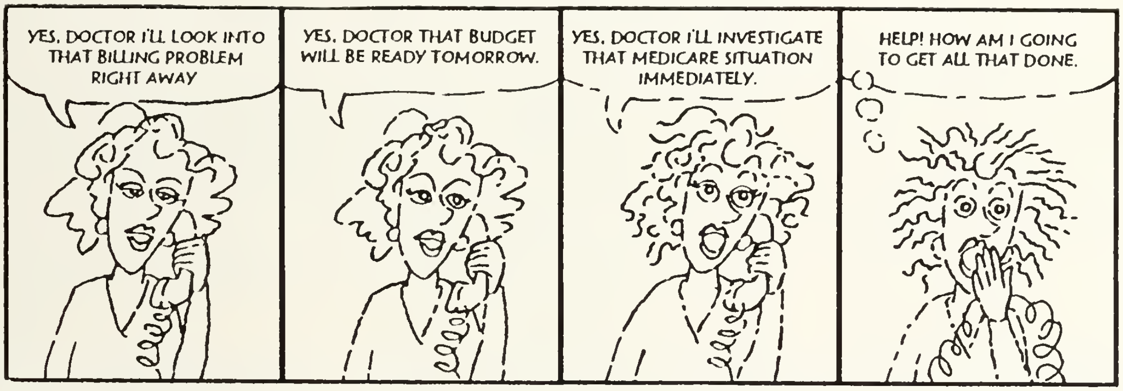
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Doctor's dependent(s) get cash payments up to $1,000,000.00 if a professional liability judgment goes "over the top" of the doctor's malpractice coverage.

ST. LOUIS, MO - Doctors who want more protection for their family's lifestyle usually increase their malpractice coverage - and pay a big price. Now there's a new, low cost alternative called FutureGuard.

FutureGuard pays up to $1,000,000.00 if a judgment is satisfied by an amount higher than the doctor's malpractice coverage.

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FutureGuard doesn't insure the doctor. Instead, it insures a dependent who relies on the doctor's income and assets. The insured dependent is usually the doctor's spouse, but it could also be a child, parent, co-habitor, legal trust, or other entity.

FutureGuard coverage means that a medical family's lifestyle and personal dignity can be preserved, even though the doctor's income and assets are taken away by an excess malpractice judgment.

AN EXAMPLE OF HOW FutureGuard WORKS

Let's say you have $500,000.00 in malpractice insurance, but a judgment of $750,000.00 comes down against you. You are personally liable for the extra $250,000.00. Your ability to support your family's lifestyle could be crippled, or even wiped out, for months or years.

But if your insured dependent has FutureGuard, we'll step in and pay 80% of the reduction in standard of living ($200,000.00 in this example) caused by satisfaction of the excess judgment. FutureGuard offers coverage up to $1,000,000.00.

You'll be hearing a lot of talk about FutureGuard at medical and financial planning meetings in the near future because this is the first good news doctors have had about insurance in a long time.

COMPLETE INFORMATION SENT ALONG WITH YOUR FREE QUOTE

Phone or FAX (both toll free), or mail, the information requested below. We'll immediately mail back a free quote showing you the premium and coverage choices available.

We'll also send more information about FutureGuard, including a special brochure for your financial advisor. If FutureGuard has a place in your plans, then have the prospective insured dependent apply using the application sent along with the Free Quote.

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FUTUREGUARD℠ FREE QUOTE REQUEST

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P.O. Box 460350, St. Louis, MO 63146-7350

Name of Prospective Insured Dependent ____________________

Doctor's Name ____________________

Residence Address ____________________

City/State/ZIP ____________________

Office Phone (To be used only if added info is needed) (   ) ____________________

Current Medical Specialty(ies) ____________________

Former Medical Specialty(ies) (for past 10 years) ____________________

List surgical procedures routinely performed ____________________

State(s) where currently licensed ____________________

States where formerly licensed (for past 10 years) ____________________

Amount of Professional Liability Insurance now carried $ ____________________

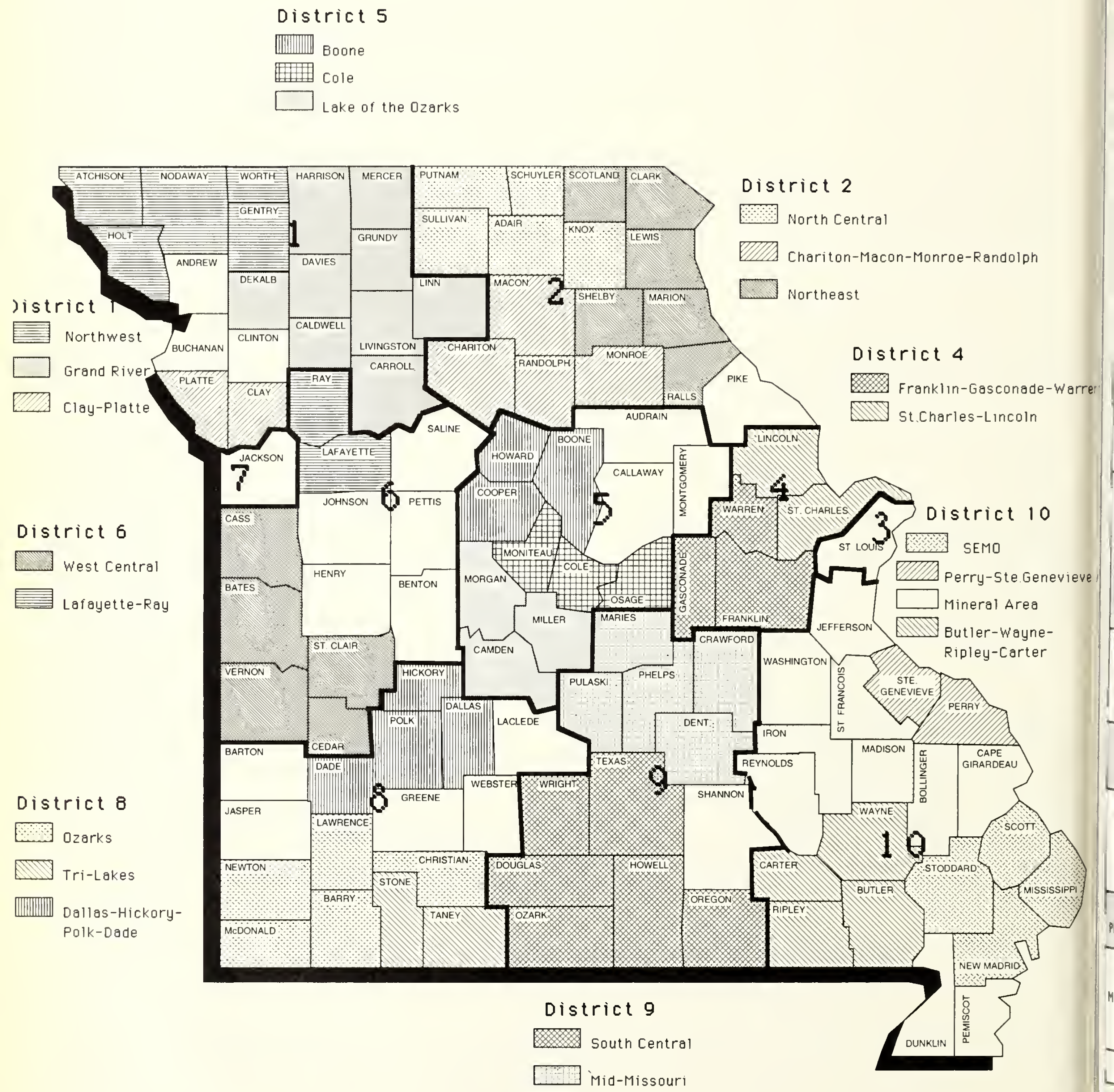
Is the doctor involved with delivery of babies? ☐ YES ☐ NO

02

Insurance Options for MSMA Members

Professional Liability Insurance. Claims made coverage available from $200,000/$600,000 to $5/$7 million. Endorsed by MSMA.	MOMEDICO (Missouri Medical Insurance Company)	MOMEDICO 10795 Watson Road St. Louis, MO
Personal Disability Income. Benefits available up to $6,000 per month. Life-time accident/to age 65 sickness coverage. Residual disability benefit available with cost of living increase provision. An individual contract with special renewal guarantees.	Commercial Insurance Company of Newark, N.J.	Sedgwick James 2420 Pershing Rd. Suite 220 Kansas City, MO 64108 (816)842-6640
Overhead Expense Insurance. Benefits up to $100,000 per month. Optional 15-day or 30-day waiting periods after which payment begins from first day of disability and continues up to 2 years.	Commercial Insurance Company of Newark, N.J.	Sedgwick James (See above)
Accidental Death and dismemberment. Up to $100,000 coverae. May include spouse, children and employees.	Commercial Insurance Company of Newark, N.J.	Sedgwick James (See above)
Hospital indemnity Plan. $50 to $200 per day while hospitalized in addition to any other insurance. Family coverage available.	Commercial Insurance Company of Newark, N.J.	Sedgwick James (See above)
Individual Noncancelable Products. Personal, Office, Overhead, Buy/Sell products. Benefits available to members at a 15% discount.	UNUM Life Insurance Company, Portland, ME	Sedgwick James (See above
Term Life Plan. Members and employees under age 60 may enroll for amounts up to $250,000. Spouses coverage, one half amount of member or employee, up to $100,000. Dependent children may be insured for $2,500.	Continental Casualty Company	Forrest T. Jones and Co., Inc. 3130 Broadway P.O. Box 418131 Kansas City, MO 64141 1-800-821-7303
Accidental Death/Dismemberment. $25,000 guaranteed up to $100,000.	Continental Casualty Company	Forrest T. Jones and Co., Inc. (See Above)
Major Medical Plan. Pays up to a lifetime of $1,000,000. Deductibles of $200, $500, $1,000. Coverage available to members, employees, and dependents, with survivor benefits. Extremely low cost policy.	Continental Casualty Company	Forrest T. Jones and Co., Inc. (See Above)
The Dodson Plan. The Dodson Plan gives participating physicians the opportunity to earn yearly dividends, depending on claim costs. MSMA members received a 10% return of premium in 1990.	Casualty Reciprocal Exchange, Member of Dodson Group	Dodson Group 9201 State Line Road Kansas City, MO 64114 1-800-825-3760
Retirement and Financial Planning. Retirement services including investment advice, plan administration and IRS approved prototype plan documents. Financial planning including estate, retirement, investment, income tax and insurnace analysis.	MonetaMed, A Moneta Group Program	Moneta Group, Inc. 700 Corporate Park Drive Suite 300 St. Louis, MO 63105 1-800-033-1301 in St. Louis, (314)726-2300

State Map with District and Component Society Boundaries


District 5
▥ Boone
▦ Cole
☐ Lake of the Ozarks
District 2
▨ North Central
▨ Chariton-Macon-Monroe-Randolph
▨ Northeast
istrict 1
▤ Northwest
☐ Grand River
▨ Clay-Platte
District 4
▨ Franklin-Gasconade-Warre
▨ St.Charles-Lincoln
District 10
▨ SEMO
▨ Perry-Ste.Genevieve
☐ Mineral Area
▨ Butler-Wayne-Ripley-Carter
District 6
▨ West Central
▤ Lafayette-Ray
District 8
▨ Ozarks
▨ Tri-Lakes
▥ Dallas-Hickory-Polk-Dade
District 9
▨ South Central
▦ Mid-Missouri
1
2
3
4
5
6
7
8
9
10
ATCHISON
NODAWAY
WORTH
HARRISON
MERCER
PUTNAM
SCHUYLER
SCOTLAND
CLARK
GENTRY
HOLT
ANDREW
DAVIES
GRUNDY
SULLIVAN
ADAIR
KNOX
LEWIS
DEKALB
LINN
MACON
SHELBY
MARION
BUCHANAN
CLINTON
CALDWELL
LIVINGSTON
CHARITON
RANDOLPH
MONROE
RALLS
PIKE
PLATTE
CLAY
RAY
CARROLL
SALINE
AUDRAIN
JACKSON
LAFAYETTE
HOWARD
BOONE
CALLAWAY
MONTGOMERY
LINCOLN
JOHNSON
PETTIS
COOPER
WARREN
ST. CHARLES
ST LOUIS
CASS
HENRY
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FRANKLIN
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STE. GENEVIEVE
PERRY
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DALLAS
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DENT
IRON
CEDAR
BARTON
MADISON
CAPE GIRARDEAU
DADE
TEXAS
REYNOLDS
BOLLINGER
JASPER
WEBSTER
WRIGHT
GREENE
SHANNON
LAWRENCE
WAYNE
SCOTT
CHRISTIAN
DOUGLAS
HOWELL
CARTER
STODDARD
NEWTON
STONE
BARRY
OREGON
BUTLER
MISSISSIPPI
TANEY
OZARK
RIPLEY
McDONALD
NEW MADRID
PEMISCOT
DUNKLIN

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SECOND	Carl Kruse, M.D. Palmyra	Chariton-Macon-Monroe-Randolph(046), North Central (148), Northeast (150), Pike (186)	Aldair, Chariton, Clark, Knox, Lewis, Macon, Marion, Monroe, Pike, Putnam, Ralls, Randolph, Schyyler, Scotland, Shelby, Sullivan
THIRD	Gordon M. Goldman, M.D., St. Louis, Robert N. Miller, M.D., St. Louis, Arturo Montes, MD, Florissant, Daniel O'Sullivan, M.D., St. Louis, Meredith Payne, M.D., Chesterfield, Frederick D. Peterson, M.D., St. Louis	St. Louis Metropolitan (190)	St. Louis County and City
FOURTH	Sammy L. Farrell, M.D. Washington	Franklin-Gasconade-Warren (074), St. Charles-Lincoln (189)	Franklin, Gasconade, Lincoln, St. Charles, Warren
FIFTH	Jerry Kennett, M.D., Columbia,H. Jerry Murrell, M.D., Columbia	Audrain (014), Boone (026) (includes Cooper-Howard), Callaway (038), Cole (058) (includes Moniteau-Osage), Lake of the Ozarks (120), Montgomery (146)	Audrain, Boone, Callaway, Camden, Cole, Cooper, Howard, Miller, Moniteau, Montgomery, Morgan, Osage
SIXTH	A.J. Campbell, M.D., Sedalia	Henry (086) Johnson (110), Lafayette-Ray (118), Pettis (178), Saline (198), West Central (214)	Bates, Benton(*), Cass, Cedar, Henry, Johnson, Lafayette, Pettis, Ray, St. Clair, Saline, Vernon
SEVENTH	Steven Buie, M.D., Lee's Summit, William Dorzab, M.D., Kansas City, Frederick W. Hahn, M.D., Kansas City, Robert T. Gibbons, Jr., M.D., Overland Park, KS	Metro Med - Greater Kansas City (125)	Kansas City and Jackson County
EIGHTH	David W. Hall, M.D., Rogersville Duane Hellam, M.D., Springfield	Barton(018), Dallas-Hickory-Polk-Dade (066), Greene (082), Jasper(102), Laclede (115), Ozarks (166), Tri-Lakes (208), Webster(210)	Barry, Barton, Christian, Dade, Dallas, Greene, Hickory, Jasper, Lawrence, Laclede, McDonald, Newton, Polk, Stone, Taney, Webster
NINTH	David O. Barbe, M.D., Mountain Grove	Mid-Missouri (135), South Central (206)	Crawford, Dent, Douglas, Howell, Maries, Oregon, Ozark, Phelps, Pulaski, Shannon(*), Texas, Wright
TENTH	William C. Shell, M.D., Sikeston	Butler-Wayne-Ripley-Carter (034), Cape Girardeau (042), Dunklin (070), Jefferson (106), Mineral Area (138), Pemiscot (170), Perry-Ste. Genevieve (174), SEMO (202)	Bollinger, Butler, Cape Girardeau, Carter, Dunklin, Iron, Jefferson, Madison, Mississippi, New Madrid, Pemiscot, Perry, Reynolds, Ripley, St. Francois, Ste. Genevieve, Scott, Stoddard, Washington, Wayne
Resident Physician Secton	Karen Zanol, M.D., Columbia	Resident Physican Section (215)	Statewide
Medical Students	Philip J. Keizer, St. Louis	Medical Students - St Louis University (216), University of Missouri - Columbia (218), University of Missouri - Kansas City (220), Washington University (222)	Statewide

(*) indiciates counties with no medical organizations

Alphabetical Roster of Members

Including name of city and code number of each member's component medical society.

A

Aaron, Geo	Shawnee Mission	125
Abada, Roland	St. Louis	190
Abadir, Rushdy	Columbia	026
Abbott, David A	St. Louis	190
Abdou, Nancy L	Kansas City	125
Abel, Charles C	St. Louis	190
Abelardo, Miguel I	St Louis	190
Abele, Wm A	Boonville	026
Abella, Ben Zulueta	Kansas City	125
Abend, Melvin N	Kansas City	125
Abercrombie, Keith J	Kansas City	125
Abernathie, Dennis L	Columbia	026
Abichandani, Lachman K	Chesterfield	190
Abinoja, Conrado B	St. Louis	190
Abodeely, Daniel A	St. Louis	190
Abrams, Bernard M	Kansas City	125
Abu Dalu, Ziad	St. Louis	190
Accardo, Pasquale J	St. Louis	190
Aceto, Thomas , Jr.	St. Louis	190
Ackerman, Lauren	Setauket	190
Acuff, R. Phillip	St. Joseph	030
Adams, Allen G	St. Louis	190
Adams, Mark A	Columbia	026
Adams, Riley R	Cape Girardeau	042
Adams, Robert B	Joplin	102
Adams, W. Stuart	Florissant	190
Adelman, Arthur	Shawnee Mission	125
Adelmann, Eugene	St. Louis	190
Adler, Benard C	St. Louis	190
Adler, Federico	Kansas City	125
Aeder, Mark I	Kansas City	125
Aff-Drum, Helen	St Louis	190
Afuwape, Emanuel A	E. St Louis	190
Agasino, Gaudencio L	Sullivan	074
Aguinaldo, Jaime A	St Louis	190
Ahadi, Abd U	St Louis	190
Ahern, Archibald M	St. Louis	190
Ahlering, Christopher L	St. Louis	190
Ahlering, George P	St. Louis	190
Ahlering, George H	St. Louis	190
Ahlum, Sandra J	Hannibal	150
Ahlvin, Robt C	Sikeston	202
Ahmad, Aqeeb	St. Louis	190
Ahmad, Bashir	Pacific	190
Ahmad, Naseer	St. Louis	190
Ahmad, Nusrat J	Ballwin	190
Ahmann, Thomas M	Mexico	014
Ahmed, Iftekhar	Kansas City	125
Ahuja, Suraj P	Kansas City	125
Ailor, Edgar I	Columbia	026
Ailor, Susan K	Columbia	026
Aitken, Louis F	St. Louis	190
Ajans, Zaki A	Mexico	014
Aker, Umit T	St. Louis	190
Akin, C. David	Independence	125
Akremi, Janet E	Greenfield	066
Al-Aly, Robert M	St. Louis	190
Al-Shathir, Saad	Joplin	102
Albanna, Faisal J	St. Louis	190
Albano, Benj I	Crystal City	106
Albano, Grace A	Lee's Summit	215
Albera, Victor H	St. Clair	190
Alberg, Marvin R	Kansas City	125
Albers, Janet R	Springfield	050
Albert, I. Renee	Overland	190
Albright, Patti W	Kansas City	125
Albritton, Michael A	Springfield	082
Albus, Thomas E	Bridgeton	190
Alcancia, Elpidio Y	Springfield	082
Alderman, Lillian C	Liberty	050
Aldridge, George A	Poplar Bluff	034
Alegre, Jorge M	Chesterfield	190
Aleksander, Bernardo G	El Paso	190
Alex, Morris	St. Louis	190

Component Medical Society Codes

002	MSMA Only
010	Andrew
014	Audrain
018	Barton
026	Boone
030	Buchanan
034	Butler-Wayne-Ripley-Carter
038	Callaway
042	Cape Girardeau
046	Chariton-Macon-Monroe-Randolph
050	Clay-Platte
054	Clinton
058	Cole
066	Dallas-Hickory-Polk-Dade
070	Dunklin
074	Franklin-Gasconade-Warren
078	Grand River
082	Greene
086	Henry
102	Jasper
106	Jefferson
110	Johnson
115	Laclede
118	Lafayette-Ray
120	Lake of the Ozarks
125	Metro Med - Greater Kansas City
135	Mid-Missouri
138	Mineral Area
146	Montgomery
148	North Central
150	Northeast
158	Northwest
166	Ozarks
170	Pemiscot
174	Perry-Ste. Genevieve
178	Pettis
186	Pike
189	St. Charles-Lincoln
190	St. Louis Metropolitan
198	Saline
202	SEMO
206	South Central
208	Tri-Lakes
210	Webster
214	West Central
215	Resident Physician Section
216	St. Louis University
218	University of Missouri-Columbia
220	University of Missouri-Kansas City
222	Washington University

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*Doctor of osteopathy.

Alexander, George K	190	St. Louis
Alexander, Thomas	215	Columbia
Alfie, Salomon	125	Shawnee Mission
Ali, Mohammed E	125	Independence
Ali, Syed S	190	Granite City
Alias, Susy	002	St.Louis
Allain, James J	050	Shawnee Mission
Allan, James E	058	Jefferson City
Allan, James R	120	Four Seasons
Allcorn, Donald K	178	Lincoln
Allego, Melquiadito M	174	Perryville
Allen, Arthur A, II	125	Shawnee Mission
Allen, Brent T	190	St. Louis
Allen, David O	102	Bella Vista
Allen, James H	190	St. Louis
Allen, Jerry H	082	Springfield
Allen, Jerry H	074	Washington
Allen, Mark J	125	Kansas City
Allen, Melvin A	190	St Louis
Allen, Robert W	026	Columbia
Allen, Robt E	125	Kansas City
Allen, Thomas P	125	Kansas City
Allen, Willard M	190	Glenwood
Allen, William Corwin	026	Columbia
Allen, Wm C	026	Columbia
Allison, James B	082	Springfield
Allphin, Barbara J	125	Kansas City
Almiron, Osias A	190	House Springs
Almuttar, Wasif F	158	Maryville
Alonso, J. Mario , Jr.	190	St Louis
Alonso-Yague, Pascual	190	Florissant
Alsop, Webb S, Jr.	125	Shawnee Mission
Altemeier, William A, III	026	Columbia
Altepeter, H. Martin	190	St. Louis
Altomare, Edward P	125	Kansas City
Alul, Mohammad Ali H	189	St Charles
Alvarez, Ulises C	190	Florissant
Alyea, James O	026	Columbia
Amato, Maryellen	190	St. Louis
Ames, Mary B	125	St. Joseph
Amin, Navin J	190	St Louis
Amini, Jafar	125	Kansas City
Amjad, Mohammad T	190	St. Louis
Ammatelli, Francis J	125	Kansas City
Amoury, Raymond A	125	Kansas City
Anand, Sanjay K	215	Merriam
Ancheta, Apolinario A	082	Springfield
Andersen, David A	190	St. Louis
Anderson, Charles B	190	St. Louis
Anderson, Daphne W	082	Springfield
Anderson, David J	190	St. Louis
Anderson, Dixie J	190	St. Louis
Anderson, Douglas A	082	Springfield
Anderson, Frank K	189	St. Charles
Anderson, Lynn A	082	Springfield
Anderson, Paul B	166	Neosho
Anderson, Philip C	026	Columbia
Anderson, Raymond B	125	Shawnee Mission
Anderson, Thos R	026	Columbia
Andes, Elizabeth A	125	Kansas City
Andres, Edward H	030	St Joseph
Andrews, Elizabeth J	082	Springfield
Andrews, Paul E	082	Springfield
Andrus, Bailey C	125	Leawood
Andrus, Charles H	190	St. Louis
Anglo, Luis J	215	Columbia
Anglo, Luis B	190	St Louis
Anslinger, David L	190	Chesterfield
Anstey, Geo C	190	St. Ann
Anstey, John T	190	St. Ann
Anthony, Dallas D	082	Springfield
Anthony, James P	125	Kansas City
Apostol, Andres G	166	Monett
Appelbaum, James S	125	Kansas City
Appelbaum, John K	002	St. Louis
Applewhite, Thomas A	190	St. Louis
Apprill, Phillip G	190	St. Louis
Apte, Sunil M	074	Washington
Arbab, Ali A	125	Kansas City
Arbaugh, Scott J	190	Florissant
Archer, Carol R	002	St. Louis
Arenos, Proceso T	190	St. Louis
Arias, Fernando	190	St Louis
Arms, Arnold V	125	Leawood
Armstrong, Jay H	050	Big Bear City
Armstrong, Stephen D	082	Springfield
Arneson, Axel N	190	St Louis
Arney, Wm G	190	St. Louis
Arnold, John D	125	Fairway
Arnold, Kenneth J	190	Chesterfield
Arnold, Lowry K	125	Blue Springs
Arnold, Paul N	082	Springfield
Arnold, Richard C	026	Columbia
Arnot, John P	190	St Louis
Aronberg, Jerome M	190	St Louis
Arribas, Aurora I	125	Kansas City
Arribas, Neva P	190	St Louis
Arribas, Romeo F	125	Blue Springs
Arst, Herbert E	050	Kansas City
Arthaud, J B	026	Columbia
Asaro, Phillip V	190	St. Louis
Asel, Norman D	026	Columbia
Ash, Charles J	082	Springfield
Ashby, Jennifer D	125	No Kansas City
Ashcraft, Keith W	125	Overland Park
Ashcraft, Walter C	106	Crystal City
Asher, Irving M	026	Columbia
*Asher, Kennett D	042	Jackson
Ashley, Lillard G, Jr.	125	Kansas City
Ashley, Michael E	082	Springfield
Ashley, Thos E	082	Springfield
Askew, John H	202	Sikeston
Assi, Nizar A	215	St. Louis
Assil, Kerry K	190	St. Louis
Atchison, Amy L	215	Kansas City
Atkinson, Lance D	082	Springfield
Atwell, Floyd C	125	Shawnee Mission
Atwood, Steven D	082	Springfield
Aubuchon, Craig E	190	St. Louis
Auclair, Ronald J	190	St. Louis
Auer, Arthur I	190	St Louis
Aufderheide, G. Russell	190	St Louis
Augustin, Cesar	190	St. Louis
Aulenbacher, Carl E	074	Ft. Lauderdale
Auner, Cecil R	082	Springfield
Auner, J. David	138	Ironton
Austin, George M	125	Independence
Averill, Keith H	125	Mission Hills
Avery, David M	082	Springfield
Avins, Laurence R	190	St. Louis
Avioli, Louis V	190	St. Louis
Awadalla, Sylvia	190	St. Louis
Axness, Mark E	082	Springfield
Ayata, Sedat M	190	St Louis
Aydt, Sarah A	042	Cape Girardeau
Aykent, Yavuz	190	St. Louis
Aylward, Howard J, Sr.	190	Santa Barbara
Aylward, Howard J, Jr.	190	St. Louis
Ayres, Willa J	125	Kansas City
Ayvazian, Vatche H	190	St. Louis
Azan, Abraham N	178	Sedalia
Azan, Kenneth N	178	Sedalia
Azzam, Farid J	190	St. Louis

B

*Baade, Norman F	030	St. Joseph
Babar, Salama S	215	Chesterfield
Babka, Joseph J	190	St. Louis
Bach, Lysle M	150	Hannibal
Back, Donald K	082	Springfield
Backer, Matt H, Jr.	190	St. Louis
Backer, Robert J	190	St. Louis
Backstrom, Jay T	125	Kansas City
Bacon, Dana S	215	Kansas City
Bade, Bruce	046	Moberly
*Bader, Larry W	026	Columbia
Bagby, Jack M, Jr	082	Springfield
Baglan, Robert J	190	St. Louis
Bagwe, Lata R	190	St. Louis
Bagwe, Ranjit M	189	St Charles

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*Doctor of osteopathy.

Bahn, Charles F	Prescott	042
Bai, Samuel S	Festus	106
Baik, Kenneth Y	Marshall	198
Bailey, Alan H	Springfield	082
Bailey, Gregory J	Chesterfield	190
Bailey, Marsha L	Arnold	190
Bailey, Sean B	St. Louis	215
Bailey, Wm H	St. Louis	190
Bailiff, Robert	Springfield	082
Baird, Keim L	St. Charles	189
Baker, Carl N	St. Louis	190
Baker, Donald L	Union	074
Baker, Josephine D	Moberly	046
Baker, Marion H	Liberty	215
Baker, Philip J	Independence	125
Baker, Sherwood	Columbia	026
Balcer, Charlotte M	Jefferson City	058
Baldwin, Richard M	Springfield	082
Baldwin, Richard , Jr.	St. Louis	190
Baldwin, Theodore R	Excelsior Spgs.	118
Bale, Robert D	St. Louis	190
Balfe, Dennis M	St. Louis	190
Ball, David A	Joplin	102
Ballal, Hebri S	St. Louis	190
Ballard, Dewey P	St Joseph	030
Ballard, V. Bryce	Shawnee Mission	125
Ballinger, Walter F	St. Louis	190
Balster, Vernon H	St. Louis	190
Bandle, Donald F	St. Louis	190
Banerjee, Dilip	Washington	074
Banez, Colita R	St. Louis	190
Bankuti, Ferenc	Kansas City	125
Banton, M. Roman	St. Louis	190
Banton, Thomas J	Florissant	190
Banton, William C, II	St Louis	190
Barbe, David O	Mountain Grove	206
Barbee, Chas W	Columbia	026
Barber, Gregory B	Kansas City	125
Barbour, Marvin R	Poplar Bluff	034
Bardsley, John L	St Louis	190
Bare, Chester I, Jr.	Kansas City	125
Bare, Edward F	Tarkio	158
Bareis, Robt J	Marshfield	210
Barelli, Pat A	Shawnee Mission	125
Bari, Wagih A	St. Louis	190
Barker, Edward T	St Louis	190
Barloon, James H	Kansas City	125
Barlow, Val John	Chesterfield	190
Barnard, John L, Jr.	Kansas City	125
Barnes, Larry G	Neosho	166
Barnett, Floyd A	Paris	046
Barnhill, Floyd R	Springfield	082
Barnthouse, Cris D	Kansas City	125
Barnthouse, Joseph R	Kansas City	125
Barr, Glenn A	Kansas City	125
Barr, W. Kent	Kansas City	125
Barragan, Hector D	St. Louis	190
Barrett, Scott R, Sr.	Columbia	190
Barrow, Jack	St Louis	190
Barry, Wm B	Kansas City	125
Bart, Gerald N	St. Louis	190
Bartell, Michael F	St. Louis	190
Barter, Bruce	Kansas City	125
Bartholomew, Kenneth K	Quincy	002
Bartlett, Hugh C	Rolla	135
Bartlett, John E	Springfield	082
Bartley, Richard L	Springfield	082
Bartnick, Mitchel L	St. Louis	190
Barton, Jean C	Kansas City	125
Barton, Premsri T	St. Louis	190
Bartulica, Nicholas	St Joseph	030
Bashford, Eileen A	No Kansas City	050
Baska, Richard E	Kansas City	125
Baskin, Morrisa	Columbia	215
Baskurt, Mehmet V	Poplar Bluff	034
Basler, Joseph W	Crestwood	190
Bass, Barry J	Rolla	135
Bass, James J	Rolla	135
Bass, Walter R	Raytown	125
Bassman, Donald R	St. Louis	190
Batan-Co, Ruby L	Chesterfield	190
Batchu, Sudhir S	Columbia	215
Bateman, Timothy M	Kansas City	125
Bates, G. Comer	Kansas City	050
Batts, Barbara A	Kansas City	125
Baue, Arthur E	St. Louis	190
Bauer, Daniel J	St. Louis	190
Bauer, John D	St. Louis	190
Bauer, Lafe W	Prairie Village	125
Baula, Armindo G	St. Louis	190
Bauman, Alan E	Kansas City	125
Bauman, Henry C	St. Joseph	158
Baumann, Albert R	Steelville	135
Baumer, Kevin A	St.Louis	215
Bauschard, Frederick D	St. Louis	190
Bautista, Rogelio L	Moberly	046
Bautz, James B	Kansas City	125
Bauwens, Daniel B	Chesterfield	190
Bay, Merrill R	Blue Springs	125
Bayer, William L	Kansas City	125
Beal, Catherine E	St. Louis	190
Beall, McPherson S, Jr.	Kansas City	125
Beare, Lucia V	St. Louis	190
Beato, David L	St Louis	190
Beatty, Eugene C	Shawnee Mission	125
Beatty, Robert M	Kansas City	125
Beaty, Wm R	St. Ann	190
Beauchamp, Gary D	Kansas City	125
Beck, Calvin E	Kansas City	125
Beck, Marcus R	Columbia	026
Beck, Paul M	St. Joseph	030
Becker, Bernard	St. Louis	190
Becker, Robt L	St. Louis	190
Becker, Rolfe A	Kansas City	125
Becker, Stanley C	St Louis	190
Becker, William L	Kirkwood	190
Beckett, Wm. Wilson	Columbia	026
Beckette, Edmund	St. Louis	190
Beckman, Robert F	St. Louis	002
Bedwinek, John M	St. Louis	190
Beeks, John W	Kansas City	125
Beesley, Kari	Olathe	215
Beggs, Charles W	Liberty	050
Behbahani, Parviz M	Bridgeton	190
Beheler, Edward M	St. Joseph	030
Behrend, Ann E	Kansas City	125
Behrends, Steven H	Kansas City	125
Behrens, Donald T	St Louis	190
Behrens, Gerald L	St. Louis	190
Beidle, Raymond J	Bridgeton	190
Beitman, Bernard D	Columbia	026
Belden, Edgar A	Jefferson City	058
Belden, Jeffery L	Columbia	026
Belen, Marietta	Festus	106
Belew, Joe E	Chesterfield	190
Belew, Mark	Florissant	190
Bell, Hubert H	Kansas City	125
Bell, Laird A	Springfield	082
Bell, Malinda H	Shawnee Mission	125
Bell, Stephen	St. Louis	190
Bell, Wm F	Lee's Summit	125
Beller, Thomas A	Kansas City	125
Bellus, Gary A	Brentwood	215
Belshe, Robert B	St. Louis	190
Belshe, Sidney B	Jefferson City	058
Benage, Clarence M	St. Louis	190
Bender, Walter L	Kansas City	125
Benecke, James E, Jr.	St. Louis	190
Benedett, Robert E	Springfield	082
Benedict, William W	Chesterfield	190
Benitez, Jose A	St. Louis	190
Bennett, Danny L	Kansas City	125
Bennett, James D	Leawood	125
Bennett, John E	Jefferson City	058
Bennett, John	St. Charles	190
Bennett, Kenneth J	St. Louis	190
Bennett, Robert U	Springfield	082
Benoist, Walter F	Chesterfield	190
Benson, Larry E	No. Kansas City	050
Benson, Ronald G	Springfield	082

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*Doctor of osteopathy.

Benson, Russell L	Kansas City	125
Benson, Scott C	Mesa	030
Benson, William F	Kansas City	125
Bentlage, Charles H	Joplin	102
Bentley, John D	Springfield	082
Benton, Mary Beth	Columbia	026
Benz, Stephen M	St. Louis	002
Berdy, Gregg J	Creve Coeur	190
Berdy, Susan S	St. Louis	190
Berg, Edward F	St. Louis	190
Berg, Leonard	St. Louis	190
Berg, Ralph	St Louis	190
Bergmann, Daniel J	St. Peters	189
Bergmann, Martin	St. Louis	190
Bergner, Grace E	St. Louis	190
Berkowitz, Ellis R	St. Joseph	030
Berkowitz, Wallace P	St. Louis	190
Berland, David I	St. Louis	190
Berland, Harry I	St. Louis	190
Berman, Wm	St. Louis	190
Bernabe, Florinio H	St. Louis	190
Bernabe, Ofelia M	St. Louis	190
Bernard, Lisa	Leawood	125
Berndsen, Gerard H	St. Louis	190
Berner, Carol T	Springfield	082
Bernhardt, Gary D	Overland Park	125
Bernhardt, Mark	Kansas City	125
Berni, Anthony A	St Louis	190
Bernstein, Aaron M	St Louis	190
Berrios, Carlos R	Chesterfield	215
Berry, Maxwell G	Shawnee Mission	125
Berry, Paul T	Springfield	082
Berwald, David M	Bridgeton	190
Berwald, Irvin I	Bridgeton	190
Bessey, Palmer Q	St. Louis	190
Best, John F	Springfield	082
Best, John A	Chesterfield	190
Bettasso, Bernard F	Joplin	102
Bettinger, Irene E	Kansas City	125
Bettonville, Paul J	St. Louis	190
Bettonville, Peter V	St. Louis	190
Betz, Richard J	Neosho	166
Betz, Robert F	Neosho	166
Bever, Grant A	Harrisonville	214
Bhat, Sanjay T	Manchester	215
Bhattacharya, Arjun	St Louis	190
Bhothinard, Bhisit	Poplar Bluff	034
Biber, Robert J	Independence	125
Bickel, Vern T	Lamar	018
Bickley, James E	Kansas City	125
Biel, Stanley I	Bridgeton	190
Biery, Richard M	Kansas City	125
Biest, Ann Agnew	Brentwood	215
Biggs, Alfred D, Jr.	Kansas City	125
Biggs, Fred J	Poplar Bluff	034
Biggs, Harry L	Galena	125
Biggs, John	St Louis	190
Bilchik, Ronald C	Chesterfield	190
Billingsley, John A, III	Raytown	215
Bills, Marvin L	Pensacola	125
Billy, Lawrence J	Florissant	190
Binda, Robert E	Kansas City	125
Bindbeutel, Donald A	St. Louis	190
Binnington, H B	St Louis	190
Binz, Donald E	St. Charles	189
Bircher, John L	St. Louis	190
Bird, H. Waldo , Jr.	St Louis	190
Bird, Jonathon M	Farmington	138
Birenboim, Nancy	Kansas City	125
Birge, Clifford A	Richmond Hghts	190
Birgenheier, James A	Mission	215
Birkby, Wm F	Columbia	215
Birmingham, Jean E	St. Louis	190
Birnbaum, Elisa H	St. Louis	190
Bishop, Marion D	St. Louis	190
Bitar, Saad R	Manchester	215
Bizek, J L	Aurora	166
Black, David L	Joplin	102
Black, Don A	Prairie Village	125
Black, Joseph T	St Louis	190
Black, Kevin J	St. Louis	215
Black, Thomas C, Jr.	Kansas City	125
Blackburn, Michael D	Columbia	026
Blackman, Cameron T	St. Louis	215
Blackwell, Charles R	St. Louis	190
Blackwell, Chas W	Columbia	026
Blackwell, F. Michael	Sikeston	202
Blades, Ross D	Springfield	082
Blaine, James R	Springfield	082
Blair, Olga M	St Louis	190
Blair, Vilray P, III	St. Louis	190
Blalock, Robt W	Marshall	198
Blanchard, Gary W	Affton	215
Blank, Michael K	De Soto	106
Blanke, Thomas J	St. Louis	190
Blankenship, Dale M	Savannah	042
Blankenship, Geo W	Neosho	166
Blanton, Jos C	Sikeston	202
Blaskiewicz, Robert J	St. Louis	190
Blath, Richard A	Chesterfield	190
Blim, R. Don	Kansas City	125
Blinder, Kevin J	Columbia	026
Block, Arnold S	St Louis	190
Bloom, Jeffrey N	St. Louis	190
Bloom, Stephen A	Kansas City	125
Bloomberg, Gordon R	St. Louis	190
Bluestone, Kenneth I	Kansas City	125
Blum, Carol A	Excelsior Spgs	002
Blum, Donald A	St. Louis	190
Blum, Philip C	Kansas City	125
Blumenthal, Mark F	Bridgeton	190
Blythe, James G	St Louis	190
Boatright, Kevin	Farmington	138
Bobrow, James C	St Louis	190
Bock, David B	Kansas City	125
Bock, Linda P	St. Louis	190
Bode, Eugene T	Kansas City	125
Bodenhausen, Gary E	Blue Springs	125
Boedeker, James P	St. Louis	190
Boesch, Jeffrey L	Webster Grove	215
Bogart, Douglas B	Kansas City	125
Bohigian, George M	St. Louis	190
***Bohn, Sara A**	Liberty	215
Bohn, William W	Kansas City	125
Bohon, Barbara D	Kansas City	125
Boldizar, Albert G	St Louis	190
Boldt, Thomas H	Bridgeton	190
Boles, C R	St. Louis	190
Boles, Murray	Columbia	026
Bolinske, Robt E	St Louis	190
Bollier, Rene P	Overland Park	125
Bollozos, George D	Ballwin	190
Bonacorsi, John	Bridgeton	190
Bondurant, Charles P	Columbia	215
Bonebrake, Albert J	Springfield	082
Bonebrake, Mac D	Springfield	082
Bonfanti, Albert L	St. Louis	190
Bonham, Roger D	Columbia	026
Boniuk, Isaac	St. Louis	190
Bonner, James S	St. Louis	190
Bonney, Saml C	Washington	074
Bonsanti, Robt L	Bridgeton	190
Boone, Daniel C	Kansas City	050
***Boone, Gina E**	Kansas City	215
Boone, Martin H, Jr	Springfield	082
Boone, Vicky L	Springfield	082
Boonshaft, Benje	St Louis	190
Bopp, J. Ronald	Joplin	102
Bopp, Sandra L	Brentwood	002
Borders, Jeffrey L	Webster Groves	215
Bordy, Marvin D	Kansas City	125
Borello, Dan J	Joplin	102
Borja, Egbert R	Springfield	082
Borkon, A. Michael	Kansas City	125
Borowsky, Benj A	St. Louis	190
Borrego, Raul A	Farmington	138
Bortnick, Arthur R	St Louis	190
Borts, Michael R	St. Louis	002
Borup, Jerrell L	Springfield	082
Botney, Kathryn	Chesterfield	190

---

*Doctor of osteopathy.

Botwin, Arnold E	125	Leawood
Bouhasin, John D	190	St Louis
Boullier, John A	190	Webster Groves
Boulware, William T	078	Chillicothe
Bourgeois, Curtis H	026	Columbia
Bourjolly, Wilson P	190	Florissant
Boveri, Jos C	190	St Louis
Bowdern, Edward H	190	St Louis
Bowe, Christopher C	190	St. Louis
Bowen, Stephen F, Jr.	190	St Louis
Bowen, William G	190	St. Louis
Bowenschulte, Bradley A	082	Springfield
Bower, James S	125	Kansas City
Bowerman, Harold H	190	Virginia Beach
Bowers, Gregory R	202	Sikeston
*Bowers, James L	215	St. Joseph
Bowers, James E	190	St. Louis
Bowersox, Warren A	190	Pacific
Bowles, G R	190	St Louis
Bowles, Richard P	050	Liberty
Bowles, Wm T	190	St Louis
Bowlin, Steven K	125	Kansas City
Bowman, Melvin C	166	Neosho
Bowman, W. Kirk	042	Cape Girardeau
Bowser, John F	125	Hot Springs
Bowser, Robert L	050	Independence
Boyarsky, Saul	190	St. Louis
Boyce, John M	178	Sedalia
Boyd, Craig W	190	St. Louis
Boyd, George K	125	Kansas City
Boyd, James H	190	St. Louis
Boydston, Catherine O	118	Odessa
Boydston, Wyatt W	118	Odessa
Boyer, Peter A	058	Jefferson City
Boylan, Peter C	125	Kansas City
Brabbee, Gregory W	190	St. Louis
Brabson, John H	082	Springfield
Braby, Howard H	125	Independence
Bradford, John F	125	Kansas City
Bradley, J. Douglas	030	St. Joseph
Bradley, James K	002	Kansas City
Bradley, Richard V	190	St. Louis
Bradley, Wm W	026	Centralia
Bradshaw, Wm D	125	Kansas City
Brady, Harry R	190	St Louis
Brady, Hugh S	118	Concordia
Brancato, Donald H	190	St Louis
Branch, Walter D, JR	125	Kansas City
Brand, Stanley N	125	Kansas City
Brandon, Frederick M	215	Oklahoma City
Brandwin, Leslie M	190	St. Louis
Brangle, Robt W	190	St Louis
Branham, Gregory H	190	St. Louis
Braun, Alan L	058	Jefferson City
Braun, Sheldon R	026	Columbia
Braun, William J	125	Kansas City
Braunschweig, Ralph	026	Columbia
Braverman, Abe E	125	Kansas City
Braverman, Alan C	002	St. Louis
Braxton, Frank W	042	Cape Girardeau
Brazos, John C	178	Sedalia
Breckenridge, Robert L	050	Kansas City
Bredemann, Jeffrey A	125	Kansas City
Breeden, Richard L	135	Rolla
Breeding, Lyle G	026	Columbia
Bregant, Robt E	058	Jefferson City
Brennan, Danl J	190	St Louis
Brennan, Geo A	190	St. Louis
Brennan, James M	190	St. Louis
Brennan, Richard J	030	St. Joseph
Brennan, Robert A, Jr.	190	St. Louis
Brennan, Robt A, Sr.	190	St. Louis
Brennan, Robt V	190	St. Louis
Brent, Lanny R, Jr	082	Springfield
Bresnahan, Dennis R	125	Kansas City
Brewer, Joseph H	125	Kansas City
Brian, Wm J	082	Springfield
Bricker, Eugene M	190	St. Louis
Brigden, Robert B	102	Joplin
Briggs, Thomas B	082	Springfield
Brigham, David W	190	Ballwin
Bright, James E	082	Springfield
Brinkman, Mark F	215	Prairie Village
Brinkman, Robert A	190	Chesterfield
Bristow, Robert B	030	St. Joseph
Britt, Cornelius L	106	Crystal City
Britton, Loretta M	125	Kansas City
Broaddus, Loren E	082	Springfield
Brock, Arthur L	125	Independence
Brockhaus, Jayne R	215	Kansas City
Brockman, M. Douglas	082	Springfield
*Brocksmith, James T	026	Columbia
Brodeur, Armand E	190	St. Louis
Brodkey, Mark J	125	Kansas City
Brody, Arnold G	190	St. Louis
Bronson, Shael S	190	St Louis
Brook, Charles J	125	Kansas City
Brookes, Robt D	190	Chesterfield
Brookreson, Alton D	034	Poplar Bluff
Brooks, John E	082	Rogersville
Brooks, Richard J	215	Kansas City
Brooks, Richard J	215	Kansas City
Brothers, Mary E	125	Kansas City
Broun, Goronwy O, Jr.	190	St. Louis
Brower, Clyde L	125	Independence
Brown, Adrian J	125	Kansas City
Brown, Barry D	190	St. Louis
Brown, Cynthia L	034	Poplar Bluff
Brown, David M	215	St.Louis
Brown, David W	082	Springfield
Brown, Elwyn S	125	Kansas City
Brown, Frances S	125	Kansas City
Brown, Frederick B	166	Aurora
Brown, Freeman F, III	190	Ballwin
Brown, Henry (Hal) S	042	Cape Girardeau
Brown, James T	082	Springfield
Brown, Katherine S	038	Overland Park
Brown, Lyle L	042	Cape Girardeau
Brown, Merlin D	030	St. Joseph
Brown, Michael S	026	Columbia
Brown, Mike J	042	Cape Girardeau
Brown, Robert J	189	St. Charles
Brown, Robt S	125	Shawnee Mission
Brown, Seymour	190	Chesterfield
Browne, Jon E	125	Kansas City
Brownsworth, Ronnie D	082	Springfield
Bruce, Helen L	190	St Louis
Bruce, Leo A	202	Sikeston
Bruce, Robert P	125	Kansas City
Brukardt, Diane T	026	Columbia
Brummett, Richard R, Jr.	030	St. Joseph
Bruno, Ellen L	026	Columbia
Bruns, Kenneth	190	St. Louis
Brunt, L. Michael	190	St. Louis
Brunworth, David	074	Washington
Bruso, Charles E	030	St. Joseph
Bryan, Wm H	125	Kansas City
Bryant, Lester R	026	Columbia
Bryant, T J	125	Kansas City
Buben, Robt W	150	Hannibal
Buchanan, Barbara N	125	Kansas City
Bucher, William C	026	Columbia
Buchert, Peter K	026	Columbia
Bucholz, Richard D	190	St. Louis
Buchwach, Kenneth A	125	Independence
Buckner, Robert C	125	Leawood
Budd, John J, Jr.	190	St. Louis
Budke, Harold A	125	Kansas City
Buehler, Carl T, Jr	120	Eldon
Buettner, John Brigham	190	Chesterfield
Buffaloe, Robert N	058	Jefferson City
Buie, Bruce R	125	Kansas City
Buie, Steven E	125	Kansas City
Bukstein, Michael J	150	Hannibal
Bult, Mark J	082	Springfield
Bumgarner, James E	026	Columbia
Bumgarner, Roger W	026	Columbia
Bunge, Nancy J	014	Mexico
Bunting, Williston P	125	Kansas City
Burch, John E	102	Naples

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*Doctor of osteopathy.

Burch, Timothy K	Overland Park	125
Burcham, Tom R	Farmington	042
Burdge, Robert E	St. Louis	190
Burford, Edwin K	Cape Girardeau	042
Burgdorf, Max H	Bridgeton	190
Burgess, Dean	St Louis	190
Burk, Emmett K	Irving	050
Burkey, Jordan W	Springfield	082
Burkhart, Edward F	St. Louis	190
Burks, Michael L	Columbia	026
Burleigh, Bruce W	Joplin	102
Burmeister, R. William	St. Louis	190
Burns, Edward L	St. Louis	190
Burns, Francis J	St. Louis	190
Burns, Michael F	St. Louis	190
Burns, Richard W	Columbia	215
Burns, Robert P	Sonoma	026
Burns, Thos W	Columbia	026
***Burris, Charles W**	Ballwin	190
Burris, Garrett C	St. Louis	190
Burroughs, Nathan D	No Kansas City	050
Burry, Virgil F	Blue Springs	125
Burst, Donald O	St. Louis	190
Burstein, Robert	Richmond Hghts	190
Bury, Jan	Overland Park	215
Bury, Robert J	Overland Park	002
Busch, Anthony K	Belleville	190
Busiek, Paul J	Springfield	082
Busse, Paul P	St. Louis	190
Bussmann, Carl E	Bridgeton	190
Bussmann, Donald W, Jr	Springfield	082
Bussmann, Donald W	Chesterfield	190
Bussmann, Yvonne L	Springfield	082
Butin, Richard E	Kansas City	125
Butler, Elza F	St Joseph	030
Butler, Stephen M	Hannibal	150
Butsch, Richard H	St. Peters	190
Butt, James H	Columbia	026
Butterfield, Mari Anne	Lee's Summit	125
Butterworth, Nelson S	Kansas City	125
Butts, James D	Rolla	135
Byars, Steven R	Kansas City	125
Byland, Saml J	Wellsville	146
***Bynum, Robert L**	Ashland	026
Byrum, Fritz A	Ballwin	190

C

Cabal, Edito	St. Louis	190
Cabal, Maria	E. St. Louis	190
Cabanas, Justo J	Shawnee Mission	125
Cabbabe, Edmond B	St. Louis	190
Cabral, Galileu	St. Louis	190
Cabrera, Tomas V	St. Peters	189
Caciolo, Carlo P	St. Louis	190
Cacioppo, Jos E	St. Louis	190
Cady, Roger K	Springfield	082
Caffrey, Raymond J	Independence	125
Cain, Alvin R	Lamar	018
Cajili, Antonio T	St Louis	190
Calabria, Rafael	Nevada	214
Calbert, Cythia C	Lee's Summit	125
Caldwell, Fred	Poplar Bluff	034
Caldwell, Fred M	Poplar Bluff	034
Caldwell, John K	Kansas City	125
Caldwell, Joseph L	Springfield	082
Calhoun, Joshua W	St. Louis	190
Calhoun, Kirk A	Kansas City	125
Calhoun, Terry L	Kansas City	050
Callahan, Donald E	St Louis	190
Callahan, Jos D	St Louis	190
Callaway, Guy D, Jr	Springfield	082
Callaway, Jo J	Kansas City	125
Callaway, Lawrence A	Kansas City	125
Callegari, Paul R	St. Louis	002
Callicoat, Paul E, Jr.	Joplin	102
Calman, Carl H	St. Louis	190
Calodney, Martin M	St. Louis	190
Calovich, Emery R	Shawnee Mission	125
***Cameron, Roger W**	Jefferson City	058
Camp, Alan D	Bridgeton	002
Campbell, Albert J	Sedalia	178
Campbell, Daniel C	Mount Vernon	166
Campbell, Edward D	Cape Girardeau	042
Campbell, Frederick B	Overland Park	125
Campbell, Gregory S	Columbia	026
Campbell, J. William	St. Louis	190
Campbell, James E	Macon	046
Campbell, James W	Advance	202
Campbell, John G	Kansas City	125
Campbell, William S, Jr	Cape Girardeau	042
Campos, Francisco J	St. Louis	190
Canaan, Samuel A, Jr.	St Louis	190
Canale, John P	St. Charles	189
Cancelada, Juan	Farmington	138
Canent, Ramon V	Kansas City	125
Canlas, Mario P	Springfield	082
Cannon, Richard E	St. Charles	189
Cantor, Harvey E	St. Louis	190
***Cantor, Sol F**	St. Louis	190
Canty, Eugene J	St Charles	189
Caplin, David A	St. Louis	190
Carden, Juan O	St. Louis	190
Carleton, Chas E	Farmington	138
Carlin, Albert L	Stanberry	158
Carlin, M. Richard	St. Louis	190
Carls, Garry L	Cahokia	190
Carlson, Arne E	Creve Coeur	190
Carlson, Hjalmar E	Overland Park	125
Carlson, John V	Mexico	014
Carlton, Lynn N	Springfield	082
Carmody, John P	St. Louis	190
Carnahan, Chas E	Columbia	026
Carnell, Billy M	Buffalo	066
Carnes, Victor M	Joplin	102
Carolla, Robert L	Springfield	082
Carpenter, Geo T	St. Joseph	030
Carpenter, James L	St Charles	189
Carpenter, Wallace	Rock Port	158
Carr, David A	Sikeston	202
Carr, George W	Jefferson City	058
Carr, Phillip W	Springfield	082
Carranza, Mauro J	St. Louis	190
Carrier, John A	Ballwin	190
Carrington, Howard W	Lebanon	115
Carroll, Danny K	Belton	214
Carroll, Thos W	Lamar	018
Carron, Oscar A	Perryville	174
Carter, Edwin E	St. Louis	190
Carter, Gary L	No Kansas City	125
Carter, James S	Columbia	026
Carter, James R	Neosho	166
Carter, Robert L	Joplin	102
Carter, Ronald D	Columbia	026
Caruso, Alfred A	Kansas City	125
Caruso, Alfred C	Kansas City	125
Caruso, Peter J	Leawood	125
Cary, John M	Chesterfield	190
Case, Mary E	St. Louis	190
Case, Wm F	Kansas City	125
Casement, Brian A	Kansas City	125
Casey, Arthur L	St. Louis	190
Casey, Edwin J	St Louis	190
Casey, Eliot C	St Louis	190
Cashman, John W	Lee's Summit	125
Casidy, Shannon L	Overland Park	215
Cason, Elbert H	St. Louis	190
Cassat, James D	Washington	074
Cassels, John W, Jr.	Columbia	026
Castaneda, Marco A	Bridgeton	190
Caster, Philip W	Lebanon	115
Catanzaro, Anthony F	St Louis	190
Catanzaro, Frank J, Sr.	St Louis	190
Catanzaro, Frank J, Jr.	St. Louis	190
Catanzaro, Rudolph E	St Louis	190
Catron, David O	Cape Girardeau	042
Caughron, Michael R	Kansas City	125
Cavanaugh, Timothy B	Kansas City	125
Cayabyab, Lilibeth P	St. Louis	215
Ceaser, James H	Springfield	082

---

*Doctor of osteopathy.

Ceaser, Nancy H	Springfield	082
Centner, Paul J	Prairie Village	125
Cento, Donald	Sikeston	202
Cernik, Christine M	St. Louis	190
Chaffin, Jerald D	Branson	208
Chalkley, Judson I	Columbia	026
Chamness, James T	Vero Beach	190
Chan, Kwan-Ho "Casey"	Joplin	102
Chanasue, John A	Florissant	190
Chand, Nazar	Poplar Bluff	034
Chandler, Robt A	Kansas City	125
Chandra, Mahesh	Independence	125
Chandramohan, Nanjappa	Carthage	102
Chang, Chil K	Columbia	026
Chapman, C. Larry	Columbia	026
Chapman, James B	Cape Girardeau	042
Chapman, Jean A	Cape Girardeau	042
Chapman, Ramona Marie	Joplin	102
Charapata, Steven G	Kansas City	125
Charette, Richard P	Kansas City	125
Charles, Benj H	St. Louis	190
Charles, Elaine Z	St. Louis	215
Charles, Francois	St Louis	190
Charles, Nallathambi	Festus	106
Charnas, Raymond M	St. Louis	190
Chase, Larry K	Springfield	082
Chase, Ned B	Joplin	102
Chastain, Chas W	Flat River	138
Chaudhari, A. Basit	Cape Girardeau	042
Chaudhuri, Sudha T	Raytown	125
Chaudhuri, Tapan K	Raytown	125
Chaudhury, Triptesh K	Shawnee Mission	125
Chavala, Sudarsan	Maryville	158
Chavez, Salvador	St. Louis	190
Chavez, Victor M	St. Louis	215
Cheek, Chas W	Columbia	026
Chehval, Micheal J	St Louis	190
Chellappa, Danu	Joplin	102
Chen, Alan J	Dexter	202
Chern, Mou S	Ava	206
Chernoff, Selbert G	Lee's Summit	125
Cherre, Charles J	Chesterfield	190
Chesney, George W	Joplin	102
Chesney, John W	Joplin	102
Cheuk, Shu-Sum	Chesterfield	190
Childs, Donna S	Kansas City	125
Childs, Richard M	Kansas City	125
Chilton, Jonathan D	Kansas City	125
Chin, Mark Maw-Chang	Chesterfield	190
Chinsky, Murray	St. Ann	190
Chipongian, Raul A	St. Louis	190
Chirino, Octavio R	St. Louis	190
Chishti, M. Ishaq	St. Louis	190
Cho, Kyu S	St Louis	190
Chod, Ronald J	Chesterfield	190
Choi, Dennis W	St. Louis	190
Choi, Sei Young	St. Charles	189
Chou, Yen Ping	St. Louis	190
Choudhury, M. Hasan	Houston	206
Chouinard, Michael P	Sikeston	202
Chow, Susanne M	Overland Park	125
Christ, Martin H	St Joseph	030
Christensen, Harold L	Springfield	082
Christiansen, Sidney G	St. Joseph	030
Christiansen, Stephen D	Springfield	082
Christianson, Chas S	Mount Vernon	166
Christy, John P	Poplar Bluff	034
Christy, Raymond A	Springfield	082
Christy, Richard R	Springfield	082
Chu, Fred C	Chesterfield	190
Chu, Peter Y	Kansas City	125
Chun, Chung S	Kansas City	125
Chun, Duck S	St. Louis	190
Chung, Kap Eun	Fredericktown	138
Chung, Sophia M	St. Louis	190
Chung, T. David	Poplar Bluff	034
Churchill, Robert J	Columbia	026
Churchill, Stephen W	Kansas City	125
Ciapciak, Stanley J	St. Louis	190
Cibis, Gerhard W	Kansas City	125
Clark, David P	Columbia	026
Clark, Gail L	Chesterfield	002
Clark, Gayln V	Kansas City	215
Clark, Granville E	Kansas City	125
Clark, Irving H	Overland Park	125
Clark, Larry K	Joplin	102
Clark, Lin W	Olathe	215
Clark, Mark S	Kansas City	215
Clark, Robert C	St. Joseph	030
Clarke, Michael S	Springfield	082
Clarke, Michael J	Springfield	082
Clary, Wm F	Springfield	082
Claseman, Wilma W	St Louis	190
Clawson, James W	Springfield	082
Claycomb, Gerald K	Chesterfield	190
Clayton, Bradford E	St. Louis	002
Clayton, Edgar L	Springfield	082
Clemens, Robert M	Sedalia	178
Clever, Henry W	St Charles	189
Clever, Victor G	St Charles	189
Cline, Daniel M	Kansas City	125
Cline, Merle A	Kansas City	125
Cline, Patricia W	Kansas City	125
Clohisy, John C	St. Louis	215
Cloninger, C. Robert	St. Louis	190
Cloogman, Howard M	Overland Park	125
Clothier, Robt W	Independence	125
Clough, Chas A	Kansas City	125
Clouse, John W	Springfield	082
Coates, James G	St. Charles	190
Cobb, Milton L	St Louis	190
Cochran, Calvin D	Kansas City	215
Cochran, Thos E	Springfield	082
Cockerell, Charles F	Blue Springs	125
Cockerell, Sanford F	Independence	125
Coffee, Amos L	Willow Springs	206
Coffin, Cheryl M	St. Louis	190
Cohen, Bruce H	St. Louis	190
*Cohen, Donald L	Kansas City	125
Cohen, Edward	St. Louis	190
Cohen, Frank	Bridgeton	190
Cohen, Harry K	Overland Park	125
Cohen, Harry B	Mexico	014
Cohen, Hillard K	St Ann	190
Cohen, Joel N	Springfield	082
Cohen, Marvin C	Kansas City	125
Cohen, Robert S	St. Louis	190
Cohle, Richard R	Carthage	102
Cohn, Steven G	Kansas City	125
Cohrs, Clarence C	Moberly	046
Coin, Richard E	St. Louis	190
Cokingtin, Leovigildo C	Independence	125
Colbert, Robt S	Sikeston	202
Cole, Donald E	Kansas City	215
Cole, Harry O	Chesterfield	190
Cole, Sherman W	Kansas City	125
Cole, Wm R	Sedalia	178
Coleman, Kevin A	Atlanta	215
Coleman, Matthew J	Cape Girardeau	042
Coleman, Terrence W	Independence	125
Colglazier, Mary C	Lee's Summit	125
Collier, Robert E	N. Kansas City	125
Collins, Douglass D	Springfield	082
Collins, John W	Independence	125
Collison, R Michael	Springfield	082
Colom, George A	Kansas City	125
Colon, Luis E	St. Louis	190
Colter, Kim D	Washington	074
Colton, Sharon M	Columbia	215
Colwill, Jack M	Columbia	026
Colyer, Jeffrey W	Kansas City	215
Comas, Manuel R	St. Louis	190
*Combs, Marvin D	Albany	158
Comeau, Richard J	Dexter	202
Comens, Ruth C	St Louis	190
Comfort, Geo D	Mexico	014
Commerford, John F	St Charles	189
Conant, James F	St. Joseph	030
Conde, Gary A	Joplin	102

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*Doctor of osteopathy.

Conlin, Chris	St. Louis	215
Conn, Robert D	Kansas City	125
Conner, Patrick T	Springfield	082
Conner, W. Edwin	Kansas City	125
Conoyer, J. Michael	St. Peters	189
Conrace, Joseph E	Joplin	102
Conrad, Marshall B	St. Louis	190
Conrad, Raymond C	Springfield	082
Conway, Philip G	St. Louis	190
Conway, Robert R	Columbia	026
Cook, James R	Springfield	082
Cook, Jerry W	Kansas City	050
Cook, Katherine S	Rolla	135
Cook, Marvin	St Louis	190
Cook, Paul R	Columbia	026
Cook, Thos B	Richmond	118
Cooley, Tonya T	Independence	215
Cooper, Barry R	N Kansas City	050
Cooper, Barry J	St. Louis	190
Cooper, C Wesley	Springfield	082
Cooper, Chas W, II	Jefferson City	058
Cooper, Gary D	Liberty	050
Cooper, Glen E	Columbia	026
Cooper, James F	Bridgeton	190
Cooper, Robert W	Camdenton	120
Cooper, Robt L, II	Warrensburg	110
Cooper, Theodore	Kalamazoo	190
Cooper, Thomas J	Farmington	190
Cooper, Thomas J	Fulton	038
Cooperman, Glenn A	Chesterfield	215
Coordes, Cordie C	Chesterfield	190
Cope, James C	Sanibel	026
Copeland, Jeffrey G	St. Charles	189
Copp, Ralph	St. Louis	190
Coppinger, Thos A	Kansas City	125
Corcoran, Francis H	Joplin	102
Corday, Robt J	St. Louis	190
Cordell, Larry D	Kansas City	125
Corder, James C	St. Louis	190
Corder, Robt L	St. Joseph	030
Cordonnier, James K	Springfield	082
Cordover, Mitchell B	St. Louis	002
Cornwell, Karen R	Kansas City	125
Coronado, Mario A	St Louis	190
Corrado, Joseph A	Mexico	014
Corry, Francis M	Springfield	082
Corry, James M	St. Louis	190
Cortez, Edwin A	Kansas City	125
Cortner, Mary C	Kansas City	125
Corvalan, Juan C	St Louis	190
Corwin, Kenneth D	St. Louis	190
Coscia, Robert L	Springfield	082
Cosens, Exec. Dir., Ron	Kansas City	001
Costello, Jos P, Jr.	Chesterfield	190
Costen, William S	Chesterfield	190
Costin, Jimmy L	Poplar Bluff	034
Cotner, Mark S	Joplin	102
Cotton, Thos R	Kansas City	125
Couch, Jeffrey M	No Kansas City	050
Couchman, Ryan W	Kirkwood	190
Couchonnal, Guillermo	Shawnee Mission	125
Coulson, Forest H	Whitewater	042
Coulter, James W	Springfield	082
Couper, Nicholas B	Columbia	026
Courter, Larry P	Osage Beach	058
Cova, Reno R	Sikeston	202
Covert, Richard A	Ballwin	190
Cowan, John H	Overland Park	125
Cox, Curtis S	Jefferson City	058
Cox, James L	St. Louis	190
Cox, John P	Amazonia	030
Cox, John M	Joplin	102
Cox, Thomas E	Cape Girardeau	042
Cox, W. Welby	Springfield	082
Coxe, Wm S	St Louis	190
Coyne, Patrick M	Florissant	190
Cozean, Charles H	Cape Girardeau	042
Crabtree, H. Mark	Springfield	082
Crabtree, Jay B	Bolivar	066
Cradock, Thomas V	St Louis	190
Crafts, David	St. Louis	190
Craig, Alan G	St. Louis	190
Craig, Richard O	St Joseph	030
Craig, Robert D	Carmel	002
Craighead, Michael L	Jefferson City	058
Cramer, Quentin	Kansas City	125
Crandall, Richard E	Chesterfield	190
Crane, James P	St. Louis	190
Crane, John B	Washington	074
Crane, John L	Lee's Summit	125
Crapotta, Joseph A	St. Louis	002
Cravens, William P	Fulton	038
Craver, Jeffrey L	Bridgeton	190
Crawford, Katherine J	Carrollton	190
Crawford, Oral B	Springfield	082
Creech, Fred T	Columbia	026
Crepps, Louis F	St. Louis	190
Crespin, Stephen R	St Louis	190
Crespo, Horacio T	Warrenton	074
Crespo, Remedios R	Warrenton	074
Creswell, Lawrence L	Chesterfield	215
Crie, J. Stanley	St. Joseph	030
Crighton, John C	Springfield	082
Crighton, Kent A	Cassville	166
Crighton, M. Nanette	Springfield	082
Criscione, James R, Sr.	St. Louis	190
Criscione, James S	St. Louis	190
Criscione, James R, Jr.	St. Louis	190
Crisp, N. Denney	Independence	002
Crispell, Lawrence S	Sarasota	102
Crist, Charles L	Cape Girardeau	042
Crist, Roderic C	Cape Girardeau	042
Critchlow, J. Thomas	Mexico	014
Critchlow, Michael E	Columbia	026
Critchlow, Wm C	Sikeston	202
Crockett, James E	Kansas City	125
Croll, Gregory H	Columbia	026
Cronemeyer, Richard L	Leawood	125
Crosby, William H	Joplin	102
Crosthwait, Edward L	Springfield	082
Crotty, John P	St. Louis	190
Crouch, John A	Columbia	026
Croughan, Jack L	St. Louis	190
Crow, Martin L	Kansas City	125
*Crowell, Tamara E	Kansas City	215
Crowley, Wm J	Columbia	026
Crumpacker, Margaret	St. Louis	190
Cruz, Christopher T	St. Louis	002
Cruz, Sergio G	Monett	166
Csaki, Bela	Independence	125
Cubillo, Enrique	Chesterfield	190
Culver, Perry J, Jr.	Kansas City	125
Cummings, Kenneth C	Kansas City	125
Cundiff, H. Clay	Independence	125
Cunningham, D. Dean	Springfield	082
Cunningham, Edwin J	Chesterfield	190
Cunningham, Milamari A	Columbia	026
Cunningham, R. Raymond	Columbia	026
Cunningham, Richard D	Springfield	082
Cunningham, William F	Springfield	082
Cupp, Gerald V	Columbia	026
Cupples, Tommy E	Cape Girardeau	042
Curnow, Richard B	Liberty	050
Curran, Desmond	Kansas City	125
*Curran, Donald J	Rolla	135
Curran, Terrence	Kansas City	125
Curry, Denise T	St. Louis	190
Curry, Michael J	St Charles	189
Curry, Michael D	Columbia	026
Curtis, Jack J	Columbia	026
Cusick, J. Douglas	Overland Park	215
Custer, Philip L	St. Louis	190
Cusumano, Joseph V	St. Louis	190
Cusworth, Robert	St. Charles	189
Cutler, Harold M	St. Louis	190
Cygan, Ronald W	Kansas City	125
Cyriac, George K	Mexico	014

---

*Doctor of osteopathy.

Czebrinski, Edward W	Chesterfield	190

D

Daake, John W, Jr.	St. Louis	190
Daake, John W, Sr.	St. Louis	190
Dabbs, Wilbur D	Neosho	166
Dacey, Ralph G, Jr.	St. Louis	190
Dagartzikas, A K	St. Louis	190
Dahm, Chas H, Jr.	St. Louis	190
Daily, Donna K	Kansas City	125
Daily, James M	Springfield	082
Daley, Frank R	Hamilton	078
Dalton, Arthur R	St. Louis	190
Dalton, Timothy T	Kansas City	125
Daly, James W	Columbia	026
Dames, Richard J	St. Louis	190
Dandridge, Walter C	Joplin	102
Danforth, Wm H	St. Louis	190
Dang, Phung T	St. Louis	190
Dang, Robert C	Pleasant Hill	214
Danganan, Manuel S	Doniphan	034
*Daniels, Edna M	Cape Girardeau	042
Daniels, John S	St. Louis	190
Danielsson, Ernst P	Springfield	082
Danis, Richard K	St Louis	190
Dankner, Arnold	Chesterfield	190
Dankner, Rand E	Chesterfield	190
Danner, Shavonne L	Kansas City	125
Darnell, Dale E	Kansas City	125
Darnell, Thos F	Branson	026
Dash, Udaya N	Lake St. Louis	190
Daskalov, Zhivko	Kansas City	125
Datta, Narendar K	Crystal City	138
Daum, Harold F	Sedalia	178
Daus, Arthur S	Joplin	102
Davault, Geo K	Richmond	118
Davidner, Mark L	Kansas City	125
Davidson, Kendrick C	Leawood	125
Davidson, Morris	St. Louis	190
Davidson, Raymond P	St. Louis	190
Davis, Alexander C	Kansas City	125
Davis, Carl S	Lee's Summit	125
Davis, Charles S	Galena	102
Davis, Donald R	Overland Park	125
Davis, Ernest E	St. Louis	190
Davis, Gene L	St Louis	190
Davis, Herbert V	Kansas City	125
Davis, J. Lawrence	St. Louis	190
Davis, Jack M	Kansas City	125
Davis, Kimberly M	Kansas City	215
*Davis, Larry E	Kansas City	050
Davis, Leonard L	Mexico	014
Davis, Mary A	St. Louis	190
Davis, Mary Margaret	Jefferson City	026
Davis, Sheldon	Florissant	190
Davis, Thomas P, III	Springfield	082
Davis, Thomas N	Mountain View	138
Davis, W. Bob	Overland Park	125
Davis, Wm E	Columbia	026
Davisson, Walter F	Jefferson City	058
Day, Chester L	Prairie Village	125
*Dean, Elizabeth E	Rock Port	158
Dean, Francis D	Fayette	026
Dean, Philip D	Washington	074
Dean, Walter E	Maryville	158
Deane, Louis V, Jr.	St. Louis	190
Deardeuff, Dwight L	Rolla	135
Decanini, Mario	St Joseph	030
Deckard, Shelby W	Springfield	082
Decker, Albert I	Springfield	082
*Deffenbaugh, Larry D	Joplin	102
Dehner, Jonathan D	St. Louis	190
Dehner, Louis P	St. Louis	190
Dehning, Doug O	Independence	125
Del Pizzo, Ferdinand	St Charles	189
Del Priore, Lucian V	St.Louis	002
Del Rosario, Horacio O	Chesterfield	190
Del Valle, Fernando	Chesterfield	190
*Delaney, Adrain J, Jr.	Kansas City	125
Delcambre, Marie A	Kansas City	125
Deleste, Carlos J	Festus	106
Deligeorges, John	Kansas City	050
Dell, Robert V	Hannibal	150
Dembinski, David R	Kansas City	125
Dement, Oman E	Joplin	102
Demmy, Todd L	Columbia	026
*Dempsey, Herbert E	Lee's Summit	125
Dempsey, Herbert A	Lee's Summit	125
Dempsey, Kenneth J	Sikeston	202
Dempsey, Maureen E	Columbia	026
Denes, Bela	Bridgeton	190
Denk, Alan F	St. Louis	190
Denninghoff, James C	Columbia	026
Denninghoff, James S	Columbia	026
Dent, George W	Farmington	138
Denton, John L	Jefferson City	058
Destouet, Judy	St. Louis	190
Detje, Robert L	West Plains	206
Dettmer, Robt F	Ironton	138
Devabhaktuni, Rama Devi	Manchester	190
Dever, Robert L	Joplin	102
Devine, John B	St Louis	190
Devine, Mark W	N Kansas City	050
Devineni, V. Rao	St. Louis	190
Devins, George S	Kansas City	125
Dew, Thomas A	Chesterfield	190
Dewald, Paul A	St Louis	190
Dewein, Edward G	St Louis	190
Dexheimer, Frank R	Columbia	026
Dexter, J. Kent	Springfield	082
Dexter, James D	Columbia	026
DeBoard, James W	St. Louis	190
DeFelice, Charles E	Cape Girardeau	042
DeFeo, Frederick G	Kansas City	125
DeFeo, Theodore C	Kansas City	125
DeGenova, Gerard H	Ste Genevieve	174
DeGraff, Judith K	Mission	215
DeGuerre, Ronald K	Chesterfield	190
DeLeeuw, Karel A	Springfield	082
DeLine, Jim	Macon	046
DeMarchena, Octavio	Lynchburg	190
DeMotte, Jeanne M	Richmond	118
DePriest, Michael D	St. Joseph	030
DeSilva, Ananda	Hazelwood	190
DeSpain, John D	Columbia	026
DeUngria, Pablo C	Bridgeton	190
DeVera, Anson E	St Louis	190
Dick, Earl	Columbia	026
Dick, M. Marga	Ashland	026
Dickerson, William J	Osage Beach	120
Dieckmann, Linda L	St. Louis	215
Diehl, Antoni M	Lenexa	125
Diehl, Elizabeth W	St. Louis	190
Diemer, David P	St. Louis	190
Diemer, Jean	Cape Girardeau	042
Diemer, Kathryn M	St. Louis	190
Diemer, Peter A	St. Louis	190
Diemer, Thomas S	Cape Girardeau	042
Dierberg, Dale F	Chesterfield	074
Dierker, Harry D	Columbia	026
Diestelhorst, James A	St. Louis	190
Dieterich, Russell B	St. Charles	189
Dillard, Burl M	St. Louis	190
Dillard, Erin M	Springfield	082
Dillard, Sandy R	Joplin	102
Dills, Joseph N	Rolla	082
Dilworth, Jacquelyn B	St. Louis	190
Dimayuga, Nestor G	Mansfield	206
Dinkins, James A	Cape Girardeau	042
Ditmore, Q. Michael	Columbia	026
Dittemore, Denise C	Kansas City	215
Dix, Patricia M	Springfield	082
Dixon, Druery J	West Plains	206
Dixon, Geo D	Kansas City	125
Dixon, Herbert K	Joplin	102
Dixon, John R	Brookfield	078
DiFilippo, Emil A	St Charles	189
DiPasco, Donald J	St. Louis	190
Dlabal, Luke J, Sr.	Independence	125

---

*Doctor of osteopathy.

Dlabal, Luke J, Jr.	Independence	125
Dmytryk, Eugene T	St. Louis	190
Doan, Laura B	Raytown	125
Doane, John F	Kansas City	215
Docherty, Martin A	Kansas City	215
Dodge, Philip R	St Louis	190
Doerhoff, Adelia L	Jefferson City	058
Doerhoff, Alan R	Jefferson City	058
Doerhoff, Carl R	Jefferson City	058
Doering, Robt W	Kansas City	125
Doerr, Dale E	St. Louis	190
Doisy, Philip P	St. Louis	190
Dolan, Patrick H	St. Louis	190
Dolan, Renee C	Town & Country	190
Domann, Darrel D	Springfield	082
Domke, Henry F	New Bloomfield	058
Donahoe, James L	Clayton	190
Donati, Robert M	St. Louis	190
Donnell, Harold E	De Soto	106
Donnell, Robt H	Crystal City	106
Donnell, William S, Jr	Bolivar	066
Donovan, John F	St Louis	190
Donovan, Thomas J	St Louis	190
Dooley, Joseph M, Jr.	Chesterfield	190
Dorsch, Ervin H	Independence	125
Dorsch, Stephen E	Independence	125
Dorton, Robt K	St Louis	190
Dorzab, Linda L	Overland Park	125
Dorzab, William E	Kansas City	125
Dotson, Rachel L	Columbia	215
Douglass, Eric J	Gladstone	050
Dowell, Geo H	St Louis	190
Downard, James M	Columbia	215
Downey, James W	Mission	125
Downey, Jon P	Cape Girardeau	042
Downing, Gregory J	Shawnee Mission	125
Downs, Mary K	Springfield	082
Doyle, Chas R	St Louis	190
Drabinowicz, Sallie E	Springfield	082
Drake, Avery A	Scottsdale	135
Drake, Roy F	Mission	125
Drake, William L, Jr.	St Louis	190
Draney, Thos E	Hiwasse	125
Dreher, Richard L	Leawood	125
Drescher, Emmett B	St. Louis	190
Dresler, Carolyn	St. Louis	002
Drews, Robt C	St Louis	190
Dreyer, Carl J	St. Louis	190
Dreyer, Philip V	Huntsville	046
Dreyer, Wm F	Houston	206
Drisko, Jeanne A	Kansas City	125
Drisko, Robert M	Kansas City	125
Drisko, Robert M, II	Kansas City	125
Drozda, Joseph P, Jr.	Bridgeton	190
Druck, Norman S	Chesterfield	190
Druet, Robert L	Springfield	082
Dubin, Sol H	Independence	125
Duda, Ralph J, Jr.	Springfield	082
Dudik, Randall G	St. Joseph	030
Dueker, David K	Columbia	026
Duello, Deborah K	Lee's Summit	125
Duemler, Robt H	St. Louis	190
Duensing, George F	Springfield	082
Duer, Mildred C	Kansas City	125
Duerksen, Joseph J	Kansas City	125
Duff, James E	Springfield	082
Duff, William M	Rolla	135
Duffy, Francis G	St. Louis	190
Duffy, Oliver F	Trenton	078
Dugan, Gerald F	Kansas City	125
Duggan, Eileen D	St. Louis	215
Dugger, David E	St. Louis	190
Dukstein, Walter G, Jr.	Shawnee Mission	125
Duling, Gerald J	St Charles	189
Dumadag, Virgilio P	St Louis	190
Dumadag-Sabio, Maria C	Chesterfield	215
Duncan, David T	St. Peters	189
Duncan, Douglas M	Springfield	082
Duncan, Robt D	Springfield	082
Duncan, Wm H	Naples	125
Dunlap, Michael D	St. Joseph	030
Dunn, David B	Liberty	050
Dunn, Melanie A	Independence	002
Dunn, Robert C, Jr.	St. Louis	190
Dunphy, Cherie H	St. Louis	002
Dunshee, Robt E	Maryville	158
Dunteman, Edwin D	Manchester	215
Durel, Justin H	St. Louis	190
Durnell, Monaford D	Kansas City	125
Durr, Jon W	Florissant	190
Durrie, Daniel S	Kansas City	125
Dusek, Dennis A	St. Louis	190
Dusing, Reginald W	Lee's Summit	215
DuMont, Clement C	St. Joseph	030
DuMontier, Alan J	Chesterfield	190
DuMontier, Edward H	Farmington	138
Dwyer, Frank X	Shawnee Mission	125
Dwyer, James G	St. Louis	190
Dwyer, Joseph C	Lima	190
Dyer, Curtis W	Warrensburg	110
Dyer, Dallas J	St. Louis	190
Dyer, Gary A	St Joseph	030
***Dykstra, John S**	Kansas City	050
Dzur, James R	Cape Girardeau	042

E

Eachempati, Rama G	Ft. Gordon	190
Eachempati, Uma R	Arnold	190
Eades, Joseph W	Chesterfield	190
Early, Gerald L	St. Joseph	030
Earnest, James B	Kansas City	125
Eaton, Paula	Kansas City	125
Ebelke, David K	N Kansas City	125
Eberle, Vincent L	St. Louis	190
Eck, Birkle	St Louis	190
Eckenrode, James F	Columbia	026
Ecker, Desider B	Sun City Center	190
Eckert, Clarence T	Longboat Key	190
Edalati, David D	Kansas City	215
Edele, Eugene H	St Louis	190
Edelman, Alan H	St. Louis	190
Edmisten, Jack	Nevada	125
Edmonds, Robt W	Chesterfield	002
Edwards, Charles F	Moberly	046
Edwards, David R	Sedalia	178
Edwards, James E	St. Louis	190
Edwards, Jos C	Clayton	190
Edwards, Ryan K	Sedalia	178
Edwards, Shelley J	Kansas City	125
Edwards, Theodore F	Kansas City	050
Egan, Robert C	St. Louis	190
Egan, Thos F	St Louis	190
Egbert, Robert N	Springfield	082
Eggers, George W, Jr.	Columbia	026
Eggleston, Harry C	St Louis	190
Eggleston, Thomas F	St Louis	190
Ehlert, Tamara K	St. Louis	190
Eidelman, Jack R	St. Louis	190
Eikermann, William C	Kansas City	125
Eisemann, Gustave	Kansas City	125
Eisen, Arthur Z	St. Louis	190
Eisenmann, Benj P	New Haven	074
Ekern, H. Peter	Mexico	014
Ekunno, Josiah O	Florissant	190
Elcock-Skimming, Devera M	Ballwin	190
Eldenburg, Donald O	Sedalia	178
Eldin, Ali	St. Louis	190
Elias, David J	Blue Springs	125
Eliasson, Sven G	St. Louis	190
Elkins, Robert L	Kansas City	125
Eller, Gordon W	Cape Girardeau	042
Ellersieck, Dorothy M	St Louis	190
Ellfeldt, Howard J	Kansas City	125
Elliott, Raymond G	Shawnee Mission	125
Elliott, Wade E	Kansas City	125
Elliott, Wendell H	Poplar Bluff	034
Ellis, Francis J	Springfield	082
Ellis, Harry L	Springfield	082
Ellis, Jean H	Blue Springs	125

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*Doctor of osteopathy.

Ellis, John C	125	Independence
Ellis, Ronald L	082	Springfield
Ellsasser, James C	026	Rocheport
Elser, Otto H	125	Independence
Ely, John W	215	Columbia
Ely, Norman B	082	Springfield
Emanuel, James P	190	St. Louis
Embry, Ellen	215	Chesterfield
Emeran, George J	190	St. Louis
Emons, Matthew F	190	St. Louis
Engelberg, Alan L	190	St. Louis
Engelhardt, Robt C	034	Poplar Bluff
Engelken, Michael K	158	Mound City
English, Milton T	148	Kirksville
English, Wallace D	070	Senath
***Ennis, James R**	058	Holts Summit
Enriquez, Roman S	125	Kansas City
Eppright, Thomas D	215	Columbia
Epstein, Jay S	002	St.Louis
Ericsson, Saml E	125	Kansas City
Ernst, Edwin C, III	190	St. Louis
Ernst, Edwin C, Jr.	190	St. Louis
Ernst, Joseph G	190	St. Louis
Ernst, Richard E	190	Bridgeton
Ernst, Roland P	190	St. Louis
Esch, John G	102	Joplin
Escoffery, Richard F	190	Florissant
Esparrago, F R	166	Monett
Essmyer, Joseph K	042	Cape Girardeau
Esther, James H	190	St. Louis
Esther, John W	082	Springfield
Esther, John R	102	Joplin
Estrem, Scott A	026	Columbia
Eto, Jackson K	190	St. Louis
Ettelson, Charles D	190	Chesterfield
Eubank, David F	125	Lee's Summit
Eubank, Wm Y	125	Leawood
Evans, Ezra L	082	Springfield
Evans, George A	026	Columbia
Evans, Joseph C, Jr.	125	Independence
Evans, Lawrence L	125	Kansas City
Evans, Lawrence G, Jr.	190	St Louis
Evans, Maria L	215	Columbia
Evens, Ronald G	190	St Louis
Eversoll, Norton J	190	Hollywood
Every, Pamela D	042	Cape Girardeau
Exarhou, Klark	190	St Louis
Exon, C S	058	Jefferson City
Eyerman, Edward L	190	St. Louis

F

Fabian, Leonard W	190	St Louis
Fabito, Daniel C	190	St. Louis
Fagan, Leonard F, Jr.	190	St. Louis
Fair, Wm L	078	Chillicothe
Fairchild, James F	174	Perryville
Fajatin, Romulo J	189	St. Charles
Fakhoury, Donald A	050	Kansas City
Fallon, Richard H	190	St. Louis
Falzone, John J	058	Jefferson City
Farber, Barry S	082	Springfield
Farberman, Elliott	190	Florissant
Farkas, James R	178	Sedalia
Farley, W. Joe	082	Springfield
Farmer, Norma D	138	Farmington
Farnham, Milo M	125	Independence
Faron, Mark A	190	Chesterfield
Farrar, Michael W	125	Kansas City
Farrell, John S	190	Bridgeton
Farrell, Sammy L	074	Washington
Farthing, Gene W	082	Springfield
Farzana, Farida	190	St. Louis
Faszholz, Mark S	002	St. Louis
Fathman, Anthony E	190	Chesterfield
Favazza, Armando R	026	Columbia
Favors, Adolphus C, Jr.	190	St. Louis
Fedotin, Michael S	125	Kansas City
Fee, Chester F	125	Fairway
Fehlman, Bernard F	190	St. Louis
Feit, Robert M	190	St. Louis
Feldman, David	190	St. Louis
Feldman, Mark R	189	St. Charles
Feliciano, Wilfrido C	190	Maryland Hghts
Felker, C. Edward , III	202	Sikeston
Felker, J. Russell	042	Cape Girardeau
Feller, Harold H	190	St. Louis
Ferber, Alan J	125	Kansas City
Ferguson, John P	082	Springfield
Ferguson, John F	082	Springfield
Ferguson, John L	082	Springfield
Ferguson, Thomas B	190	St Louis
Fernandez, Fernando	030	St Joseph
Fernandez, Mark A	125	Platte City
Ferneau, James E	026	Columbia
Ferns, Francis E	125	Kansas City
Ferrara, Robert P	190	St. Louis
Ferrari, Herbert A	026	St. Louis
Ferrendelli, James A	190	St Louis
Ferris, Carl R	125	Overland Park
Ferris, Charles W, Jr.	190	St. Louis
Ferris, Robert E	058	Jefferson City
Ferry, Richard J	190	St. Louis
Fibuch, Eugene E	125	Kansas City
Figueroa, Edduyn	190	Florissant
Figueroa, Eliseo O	190	St Louis
Finch, William O	170	Anahuac
Fingert, Hyman H	190	St Louis
Fink, Leroy L	190	St. Louis
Fink, Roger L	082	Springfield
Finkel, Barney W	190	N Ft. Myers
Finn, Murray E	190	St Louis
Finnegan, Jos V	190	St Louis
Fiore, Andrew C	190	St. Louis
Fischbein, Lewis C	190	St. Louis
Fischer, Edward H	050	Gladstone
Fischer, John R	190	Hermann
Fischer, Robert	190	St. Louis
Fish, Virgil O	190	St Louis
Fisher, James K	125	Kansas City
Fisher, Jos L	030	St Joseph
Fisher, Linda	190	St. Louis
Fisher, Mary Jo	215	Nixa
***Fisher, Robert B**	026	Columbia
Fishman, Norman	190	Chesterfield
Fitch, Coy D	190	St. Louis
Fitz, John R	138	Farmington
Fitzmaurice, Laura S	125	Kansas City
FitzSimmons, James G	125	Kansas City
Fivian, Gerald J	190	St Louis
Flance, Israel J	190	St Louis
Fleming, Allan R	125	Kansas City
Fleming, David A	046	Moberly
Fleming, J. Will , Jr	046	Moberly
Fleming, Robt J	189	St Charles
Fleshman, James W	190	St. Louis
Fletcher, Robert C	125	Kansas City
Fletes, James W	190	St Louis
Flicker, Michele R	125	Kansas City
Florendo, Federico N	150	Hannibal
Florendo, Purificacion T	150	Hannibal
Flores, Eduardo D	215	Kansas City
Flores, Jhonson E	190	St. Louis
Floro, Kenneth E, Jr.	190	St. Louis
Floro, Mariano N	190	Florissant
Flotte, Sylvester A	190	St Louis
Floyd, Marla J	082	Springfield
Flug, Eric J	190	St. Louis
Flury, Kirk E	190	St. Louis
Flye, M. Wayne	190	St. Louis
Flynn, James M	125	Kansas City
Flynn, John T	190	St Louis
Fogarty, William M, Jr.	190	St. Louis
Fogel, Steven T	215	Leawood
Fogle, Philip R	082	Springfield
Folck, Wm P	125	Kansas City
Foley, Jonathon K	042	Cape Girardeau
Folkner, Albert L	110	Warrensburg
Foote, Daniel D	082	Springfield
Foote, Jerry E	026	Columbia

---

*Doctor of osteopathy.

Forand, Joseph M	St. Louis	190
Ford, Lee T	Belleville	190
Ford, Thomas E	Niagara Falls	190
Foreman, Phillip B	Hannibal	150
Forgue, Donald R	Kansas City	125
Forman, Louis H	Shawnee Mission	125
Forsman, Waldo W	St Louis	190
Forsyth, B. Todd	St. Louis	190
Forsythe, Lees C	Kansas City	125
Forsythe, Robert W	Shawnee Mission	125
Fortin, Don G	Kansas City	050
Fortin, Jorge A	Rolla	135
Foster, R. Steve	Sedalia	178
Fotopoulos, Chris K	DeQueen	120
Fouraker, Bradley D	Tampa	190
Fouts, Dallas B, Sr.	Independence	125
Fowler, Fred D	Kansas City	125
Fowler, I. Charles	Sun City Center	050
Fowler, James W	Leawood	125
Fowler, Marvin L	West Plains	206
Fowler, Wayne L, Jr.	Kansas City	125
Fox, Gerald E	St. Joseph	030
Fox, Robert E	Chesterfield	190
Fox, Thomas J	St. Louis	190
Fracasso, Paula M	St.Louis	002
Francel, Thomas J	St.Louis	002
Francis, Roger A	Osage Beach	120
Francisco, Clarence B	Kansas City	125
Francisco, Dominic S	St. Louis	190
Frank, Bruce S	St. Charles	189
Frank, Gael R	No Kansas City	125
Frank, Robert A	Kansas City	125
Franklin, Harold A	St Louis	190
Franks, Elliott L	Kansas City	125
Fraser, Danl M	St Louis	190
Fraser, Richard A	Poplar Bluff	034
Fraser, Victoria J	St. Louis	215
Frawley, Thomas F	St. Louis	190
Frazier, Robt E	Columbia	026
Frazier, Robt L	Sikeston	202
*Frederick, Mark R	Jefferson City	058
Frederickson, Neil W	St. Louis	190
Freedman, Ruth S	Clayton	190
Freeman, James A	Columbia	026
Freeman, Jerry C	Kansas City	125
Freeman, Mark E	St. Louis	215
Freeman, Michael R	Cape Girardeau	042
Freiden, Floyd J	Kansas City	125
Freiman, Paul C	Springfield	082
Frein, Donald E	Harrisonville	214
French, M. Devonne	Lee's Summit	125
Frevert, Larry F	Kansas City	125
Frewin, Paul R	Springfield	082
Frey, Jeffrey P	Columbia	026
Fried, John S	Overland Park	125
Friedman, Michael J	Kansas City	125
Friedman, Morris L	Shawnee Mission	125
Friedman, Robt H	St. Louis	190
Friedman, William H	St. Louis	190
Friedrich, Anthony P	St. Peters	215
Friend, T. Gregory	Kansas City	125
Fries, John W	St. Louis	190
Friesen, Randall G	St. Charles	189
Frissell, Dan H, Jr.	St. Genevieve	174
Fritsch, Andrew J	Joplin	102
Fritzlen, Thos J	Overland Park	125
Froehlich, Thomas W	Springfield	082
Froeschle, Ellis Birch	Rocheport	215
Frogge, Jim D	Joplin	102
Frohman, Boris	Sikeston	202
Fromme, Glenn A	Springfield	082
Frumson, Guy H	Florissant	190
Fry, Robert D	St. Louis	190
Fuchs, Geo J	Columbia	026
Fuhrman, Donald L	Shawnee Mission	125
Fuleihan, Farid M	St Louis	190
Fulks, Richard B	California	058
Fuller, Terry A	St. Louis	190
Funsch, Robert E	St Louis	190
Furla, August J	St Louis	190
Furlong, Lawrence D	Kansas City	125

G

Gabel, Michael G	St. Louis	190
Gadson, Michael T	Quincy	150
Gafford, Franklin H, IV	St. Louis	190
Gagliardo, Joseph	St. Louis	190
Gaines, Robert W	Columbia	026
Gainor, Barry J	Columbia	026
Gaitonde, Mangesh R	Lee's Summit	026
Galakatos, Andrew E	Chesterfield	190
Galant, Mark R	Belton	125
Galblum, Larry I	Kansas City	125
Gale, Arthur H	St. Louis	190
Gale, Joseph F	Chillicothe	078
Galinsky, Leon J	Tucson	166
Gall, Clifford M	Kansas City	125
Gall, Ira C	St. Louis	190
Gallagher, Corrine M	St. Louis	215
Galvez, Sisenando P	Marceline	078
Gandlmayr, Jack M	St Louis	190
Gans, Lawrence A	Florissant	190
Gansloser, Wilbert M	Clayton	190
Gantz, John A	St. Louis	190
Garcia, Delia M	Chesterfield	190
Garcia, Eduardo L	St. Louis	190
Garcia, Kathleen M	Clayton	190
Garcia-Ferrer, Eduardo A	Miami	190
Gard, Raymond F	Brookings	125
Gardner, Joe A	Joplin	102
Gardner, Jos W	Kimberling City	166
Garfinkel, Bernard T	St. Louis	190
Garfinkel, Lester S	Kansas City	125
Garmager, Kirk K	Overland Park	215
Garner, Royal S	Homestead	058
Garrard, Jacqueline M	St. Louis	215
Garrett, Elizabeth A	Columbia	026
Garrett, Ted E	St. Louis	190
Garrett, Exec VP, G. R.	St. Louis	001
Garriga, Francisco J	Florissant	190
Garrison, David L	St Joseph	030
Garrison, Roy F	Kansas City	125
Garrison, Theodore W	Camdenton	120
Garrotto, Lewis J	Columbia	026
Garvin, Charles F	Chesterfield	190
Garvin, Paul J	St. Louis	190
Gaska, Walter J	Springfield	082
Gast, Kristie L	Shawnee	215
Gatchalian, Felicitas Z	St. Louis	190
Gates, George A	St. Louis	190
Gauer, Robt J	Kansas City	050
Gauthier, Charles P	Kansas City	125
Gavankar, Sharad S	Joplin	102
Gavini, Rajendra R	St Louis	190
Gay, John W	Columbia	026
*Gayle, David R	Piedmont	034
*Gayle, Richard E	Piedmont	034
Gearhart, Wilbur H	Chesterfield	190
Gedney, Wm B	Valley Park	190
Gehm, Louis E	Butler	214
Geier, Larry J	Kansas City	125
Geise, August W	Chesterfield	190
Geisman, Richard A	St. Peters	189
Geisse, Guillermo	St Louis	190
Geller, Bruce D	Kansas City	125
Gellman, Elliot F	St Louis	190
Gelstein, Laurence D	St. Louis	190
Gendel, Jonathan	Lee's Summit	002
Gennaoui, Jad M	St. Louis	190
Gentry, Jim	Springfield	082
Gentry, Marvin C	Ava	206
Gentry, Michael A	Springfield	082
Gentsch, Kenneth W	St. Louis	190
George, Philip G	St Louis	190
Georgi, Basil A	Brooklyn	026
Geraghty, Thomas E	Kansas City	125
Gerdes, John A	Springfield	082
Gerdes, K. Eric	Springfield	082
Gerecht, Wolfe B	Springfield	082

---

*Doctor of osteopathy.

Gerhardt, Donald C	Columbia	026
German, Walter A	Springfield	082
Germann, Donald R	Kansas City	125
Gernstetter, S L	Poplar Bluff	034
Gerowin, Lance	St. Louis	190
Gerst, Aloysius C	St. Louis	190
Gessler, James A	Springfield	082
Geter, Rodney K	Springfield	082
Geurkink, John W	Joplin	102
Gholkar, Vijay R	Kansas City	125
Ghosh, Nellie	St. Louis	190
Giangiacomo, Joseph	Columbia	026
Gibb, Randall K	St. Louis	215
Gibbons, James J	St. Louis	190
*Gibbons, Jerry L	Baldwin	190
Gibbons, Robert T, Jr.	Overland Park	125
Gibson, David M	Santa Fe	125
Gibson, James D	Springfield	082
Gibson, Merlyn D	Columbia	026
Gibson, Paul H	St. Louis	190
Gibson, William P	Chesterfield	190
Gibson, Exec Dir, Lee	Columbia	001
Giddings, Frank C	Springfield	082
Gieselmann, James W	Poplar Bluff	034
*Giffen, Lawrence E	Jefferson City	058
Gifford, David L	Richland Hills	014
Gilbanks, Marjon M	Independence	002
Gilbirds, William M, II	Kansas City	050
Gilden, Jerome J	St. Louis	190
Gile, Robert J	Cape Girardeau	042
Gill, Paul J	Springfield	082
Gillispie, John L	Branson	208
Gilula, Louis A	St Louis	190
Gimpelson, Richard J	Chesterfield	190
Ginardi, Donald E	Kansas City	125
Ginsberg, B. William	Kansas City	125
Ginther, James W, Jr.	St. Louis	190
Giorgi, Lee V	Kansas City	125
Gish, E R	Fulton	038
Givler, Robt L	Kansas City	125
Gladney, John H	St Louis	190
Glaser, Larry F	Cleveland	125
Glass, Wm J	Nixa	166
Glazer, Harvey S	St. Louis	190
Glazer, Melvin L	Kansas City	125
Glazzard, Charles D	Springfield	082
Glenn, Edward A	Louisiana	186
Glenn, Theodore J	Cape Girardeau	042
Glenski, James A	Kansas City	125
Glickman, Andrew S	New York	150
Glines, Michael H	Arnold	190
Glotzbach, Ellen S	Kansas City	125
Glover, David	Warrensburg	110
Glover, Kenneth	Mount Vernon	166
Glueck, Robert M	Kansas City	125
Gnade, Albert J	St. Louis	190
Godar, Sharon A	Chesterfield	190
Goddard, Jerry L	Cape Girardeau	042
Godwin, Lehman W	Springfield	082
Goebel, Joan M	St. Louis	190
Goebel, Joel A	St. Louis	190
Goeking, C Keith	St. Joseph	030
Goerz, Ann A	Blue Springs	125
Goerz, Royal D	Independence	125
Goetz, Joseph J	Overland Park	125
Goff, John E	Joplin	102
Goheen, John R	Kansas City	125
Goins, Bonnie K	Overland Park	215
Gold, Jonathan A	St. Louis	190
Goldberg, John M	Kansas City	125
Golden, Samuel E	Springfield	082
Goldfarb, Alvin	St. Louis	190
Goldkamp, John D	St Charles	189
Goldman, Arnold M	St. Louis	190
Goldman, Barry C	Kansas City	125
Goldman, Gordon M	St. Louis	190
Goldman, Stanley L	Shawnee Mission	125
Goldring, David	St Louis	190
Goldring, James M	Columbia	026
Goldring, Sidney	St. Louis	190
Goldsich, Edward	Kansas City	125
Goldstein, David E	Columbia	026
Goldstein, Marcy A	Pacific Palsade	002
Goldstein, Marvin F	Kansas City	125
Goltschman, John P	Florissant	190
Gomez, Cesar A	St Louis	190
Gondring, William H	St Joseph	030
Gonzales, Jose H	Perryville	174
Gonzalez, Alicia D	St. Louis	190
Gonzalez, Mario G	Warrensburg	110
Good, Michael W	Springfield	082
Good, Thomas H	Kansas City	125
Goodenberger, Daniel M	St. Louis	002
Goodhope, Karen F	St. Louis	190
Goodman, Douglas E	Springfield	082
Goodman, Nathaniel	St. Louis	190
Goodrich, Steven D	St. Louis	190
Goodwin, J. Wendall	Springfield	082
Gordon, Bruce J	Columbia	026
Gordon, Glenn L	Mexico	014
Gordon, James S	Jefferson City	058
Gordon, James M	Florissant	190
Gordon, Mark E	Kansas City	050
*Gordon, Stephen M	Kansas City	125
Gose, Don F	Springfield	082
Gosek, Marek J	Warrensburg	110
Gottesman, Gary S	Olivette	215
Gotti, Edward W	Springfield	082
Gottlieb, Charlene C	St. Louis	190
Gottsch, Joseph C	Shawnee Mission	125
Gould, Ronald J	St. Louis	190
Gowda, Siddhesh	Chesterfield	190
Gowdamarajan, Rengasamy	Kansas City	125
Gowen, Rose M	St. Louis	190
Grable, James D	Cape Girardeau	042
Grace, Steve	Springfield	082
Graden, William R	Springfield	082
Grady, Ronald K	Chesterfield	190
*Graessle, Donna M	Shawnee	215
Graff, Ralph J	St. Louis	190
Graham, Bruce D	Kansas City	125
Graham, Joseph E	St. Louis	190
Graham, Wallace H	Kansas City	125
Grand, M. Gilbert	St. Louis	190
Grant, John M	St Louis	190
Grant, Neville	St Louis	190
Grant, Ruth	Springfield	082
Grant, William T	St. Louis	190
Graul, Walter P	St. Louis	190
*Graves, Karladine E	Kansas City	050
Graves, Kathleen L	Springfield	082
Graviss, Christopher P	Richmond Hghts	215
Graviss, Edward R	St. Louis	190
Gray, Diana L	St.Louis	002
Gray, Gary J	St Louis	190
Grebe, T. Keith	Joplin	102
Grechus, John J	Farmington	138
Greditzer, Harry G	St. Louis	190
Green, J. Richard	Independence	125
Green, Morton R	Belleville	190
Green, Thomas F	Independence	125
Green, Wm R	St Louis	190
Greenberg, Benjamin E	Forsyth	208
Greene, Harry L	Tucson	150
Greenfield, Jerome F	Jefferson City	058
Greenlaw, Cal W	Chillicothe	078
Greenlund, Nelson C	Nevada	214
*Greenspan, Peter B	Independence	125
Greenwood, Kerry L	Kansas City	215
Gresick, Robert J, Jr.	St. Louis	190
Gresick, Robt J	St Louis	190
Griesemer, Bernard A	Springfield	082
Griffin, Darrell L	Farmington	138
Griffin, Donald R	Kansas City	002
Griffin, M E	Springfield	066
Griffin, Olin A	Springfield	066
Griffin, Wm T	Columbia	026
Griffith, S Kent	Cape Girardeau	042
Grim, Edward M	Joplin	102
Grimes, Elwyn M	Kansas City	125

---

*Doctor of osteopathy.

Grimes, Manning E	St. Joseph	030
Grisham, Thomas D	Washington	074
Groce, Geo D	Fulton	038
Groshong, Ted D	Columbia	026
Grossberg, George T	St. Louis	190
Growdon, John A	Shawnee Mission	125
Grubb, Robert L, Jr.	St. Louis	190
Grundmann, Wm H	St Louis	190
Grunt, Jerome A	Kansas City	125
Guastello, Joseph R	Kansas City	125
Guastello, Mario J	Kansas City	125
***Guenthner, Brenda L**	Jefferson City	058
Guerra, Gaston G	Kansas City	125
Guhleman, Henry V	Jefferson City	058
Guindon, Kurt R	Columbia	026
Gujarati, Subhash B	Poplar Bluff	034
Gulick, C. Richard	St Louis	190
Gundle, Sigmund	Prairie Village	125
Gunn, Jack	Versailles	120
Gunn, Richard W	Kansas City	125
Gunn, Victoria	Jefferson City	058
Gunn, Walter T	St. Louis	190
Gunnoe, Robert E	Kansas City	125
Gunter, Joe S	Lake Ozark	030
Gupta, Mala R	Kansas City	125
Gupta, Nilakshi	Columbia	026
Gura, George M, JR.	Kansas City	125
Gurba, Carol L	Kansas City	125
Gurba, Danny M	Kansas City	125
Gurian, Lawrence E	Springfield	082
Gurucharri, Vincent P	Columbia	026
Gustafson, Jon E	Lee's Summit	125
Gutek, E. Philip	Kansas City	125
Gutierrez, Anthony C	Kansas City	125
Gutierrez-Medina, Ernesto	Florissant	190
Gutknecht, Richard	Independence	125
Gutwein, Michael B	St. Louis	190
Guy, Cynthia S	St. Louis	190
Guyer, Emily	Columbia	026
Guyol, William B, Jr.	St. Louis	190
Guze, Samuel B	St. Louis	190
Gwin, Edward	Springfield	082

H

H'Doubler, Charles	Springfield	082
H'Doubler, Francis T	Springfield	082
H'Doubler, Peter B	Springfield	082
Ha, Richard J	Hannibal	150
Haake, Gregory K	Springfield	082
Haas, Harry D	Blue Springs	125
Haas, Robert W	Liberty	050
Habermann, James H	Joplin	102
Habert, Edward R	Clarkson Valley	190
Habib, Henry N	Osage Beach	125
Habiger, Thomas G	Springfield	082
Hacker, Douglas A	Springfield	082
Hackett, Earl R	Springfield	082
Haddock, James N	St Louis	190
Haddow, Alastair D	Springfield	082
Haefner, Rebecca	Columbia	215
Hagan, John C, III	No Kansas City	050
Hagemann, Margarethe H	St. Louis	190
Hagemann, Paul O	St. Louis	190
Hagen, Douglas W	Kansas City	125
Hagen, Duane Q	St Louis	190
Hagen, Garrett A	St. Louis	190
Hahn, Bruce H	Lee's Summit	125
Hahn, Frederick W	Independence	125
Hahn, Yoram	Florissant	190
Haight, J. Max	Kansas City	125
Haith, Walter F	Kansas City	125
Hale, Thomas H	Manchester	190
Halford, Richard M	St. Louis	190
Hall, David W	Springfield	082
Hall, David G, III	Rocheport	026
Hall, Deborah M	Shawnee Mission	215
Hall, Durward G	St. Petersburg	082
***Hall, Frederick K**	Overland Park	125
Hall, Gary D	Mission	215
***Hall, John P**	Cape Girardeau	042
Hall, John C	Kansas City	125
Hall, Robt T	Kansas City	125
Hall, Stanley G	Hannibal	150
Hall, Terry E	Bethany	078
Hall-Davis, Jacquelyn	St. Louis	215
Halloran, Mark J	St. Louis	190
Halperin, Phillip H	Shawnee Mission	125
Halpin, Stephen E	Hannibal	150
Halverson, Larry W	Springfield	082
Hamburg, Eric D	Farmington	138
Hamburg, Frederic L	Springfield	082
Hamburg, Mitchell S	Kansas City	125
Hamburger, Stephen C	Shawnee Mission	125
Hamel, Peter C	Hannibal	150
Hamid, Rashid S	Brunswick	198
Hamill, Robert W	Gulfport	125
Hamilton, Caldwell K	St. Louis	190
Hamilton, Dennison R	Shawnee Mission	002
Hamilton, Eugene G	Chesterfield	190
***Hamilton, William V**	Lexington	118
Hamilton, William P	St. Louis	190
Hamilton, Wm P	Aurora	166
Hamlin, Wyeth	Hannibal	150
Hammerman, Albert M	St. Louis	190
Hammerman, Harley J	St. Louis	190
Hammerman, Marc R	St. Louis	190
Hammond, D. Wade	St. Louis	190
Hanaway, Joseph	St Louis	190
***Hancock, Thomas J**	Jefferson City	058
Handler, Fred P	Clayton	058
Handler, Michael R	St. Louis	190
Hanes, Lily A	Golden Eagle	190
Hanks, Michael S	Springfield	082
Hanley, Thomas P	St. Louis	190
Hanna, Hugh A	Warrensburg	110
Hannah, Hamner , III	Kansas City	125
Hannas, Ralston R	Kansas City	125
Hansbrough, Eugene T	Poplar Bluff	034
Hansen, Thomas L	Independence	125
Hanson, E J	Kansas City	125
Hanson, Karl H	Kansas City	125
Hanss, Armand W	Springfield	082
Hantman, Stephen L	St. Louis	190
Hantz, Oscar	Florissant	190
Harbrecht, James J	Kansas City	125
Hardacre, Ruth A	Kansas City	125
Harding, Clarke T	St. Charles	189
Hardman, William A	Springfield	082
Hardy, David A	St. Louis	190
Hardy, Guerdan	St. Louis	190
Hardy, H. Malcolm	Shawnee Mission	125
Hardy, Jeffery A	St. Louis	190
Hardy, John W	Kansas City	125
Hardy, Patrick J	Florissant	190
Hardy, Samuel W	St. Louis	190
Hardy, Stanton L	Desloge	138
Harell, Alex	St. Louis	190
Hargis, James L	Springfield	082
Hari, Magaral S	Joplin	102
Harless, Morris S	Galena	125
Harlow, Richard J, Jr	Belton	125
Harmon, Ben C	Springfield	082
Harms, James F	Nevada	214
Harms, Lawrence L	St. Louis	046
Harner, Casper G	St Joseph	030
Harper, Fleming B	St. Louis	190
Harr, Patrick B	Maryville	158
Harrin, Wm R	Kansas City	125
Harris, David J	Kansas City	125
Harris, Hugh G	Springfield	082
Harris, Hugh S, Jr.	Columbia	026
Harris, Lanny W	Kansas City	125
Harris, Louis B	Bolivar	066
Harris, Weldon L	Independence	125
***Harris, William D**	Kansas City	125
Harrison, Garth F	Kansas City	125
Harrison, Richard L	St. Louis	190
Harrison, Thomas J, Jr.	St. Charles	189
Harrison, Winston E	Columbia	026

---

*Doctor of osteopathy.

Harshman, David M	St. Louis	190
Hart, L. Wayne	Overland Park	125
Hart, William M, Jr.	St Louis	190
Hart, William G, Jr.	St. Louis	190
Hartman, Paul T	St. Louis	190
Hartman, Richard A	St. Louis	190
Hartman, Rodney C	Sedalia	178
Hartnett, Anna E	St. Louis	190
Hartnett, Thomas D	St Louis	190
Hartstein, Jack	Chesterfield	190
Hartwig, Frederick H	Kansas City	125
Hartwig, Raymond W	Overland Park	125
Hartzler, Geoffrey O	Kansas City	125
Harvey, Harold D	Springfield	082
Harvey, Judith E	Springfield	082
Harwell, J. Larry	Clayton	190
Harwell, J. Lee	Columbia	026
Hasik, Karl J	St. Peters	190
Hasler, Galen R	Springfield	082
Hassien, Joel D	Columbia	215
Hastings, Mary V	Mexico	014
Hastings, Thomas F	Mexico	014
Hatfalvi, Bela I	St. Louis	190
Hatlelid, J. Michael	St. Louis	190
Haupt, Herbert A	St. Louis	190
Hausam, Robert R	Sedalia	178
Hauser, Robert J	Jefferson City	058
Hausheer, Herman J	Independence	125
Havaldar, Kanti L	Maryville	158
Havey, John	Columbia	026
Haw, Marvin T	Columbia	026
Hawatmeh, Ibrahim S	St. Louis	190
Hawatmeh, Sam S	St. Louis	190
Hawk, Bray O	St. Louis	190
Hawker, Wm D	Chesterfield	190
Hawkins, Calvin D	Springfield	082
Hawkins, Geo L	St. Louis	190
Hawkins, John W	Independence	002
Haycraft, Gordon L	Cape Girardeau	042
Hayden, Melvin R	Camdenton	120
Hayden, Richard E	St. Louis	190
Hayek, Michael E	St. Louis	190
Hayes, Kimberly W	Independence	125
Hayes, Lawrence L	Kansas City	050
Hayes, Nancy J	Mountain Grove	206
Hayes, Paul W	St Joseph	030
Hayes, Stanley P	Springfield	082
Haynie, William W	Butler	214
Hazan, Joseph	Bridgeton	190
Hazen, Robt M	Prairie Village	125
Hazuka, David F	Shawnee Mission	125
Headrick, John A	Lake St. Louis	190
Heaney, Robert M	St. Louis	190
Heath, Jimmy D	East Prairie	202
Hecker, Jos E	Poplar Bluff	034
Hedge, S. Roy	Kansas City	125
Hedges, Richard C	Kansas City	050
Heeb, Max A	Sikeston	202
Hegde, Korgi V	St. Louis	190
Heidbrier, Edward W	St. Louis	190
Heim, Carissa M	Houston	125
Heim, Mary L	Kansas City	002
Heimburger, Elizabeth M	Columbia	026
Heimburger, Richard A	Columbia	026
Heins, Donald E	St. Joseph	030
Heins, James N	St. Louis	190
Heinz, George	Springfield	082
Helfrich, Loring	Sikeston	202
Helikson, Mary A	Columbia	026
Hellam, Duane C	Springfield	082
Heller, Randall L, Jr.	St. Louis	190
Hellerstein, Stanley	Kansas City	125
Helling, Thomas S	Kansas City	125
Hellman, Richard	Kansas City	125
Hellweg, Raymond W	Florissant	190
Helzberg, John H	Kansas City	125
Hendrickson, Barry L	St.Louis	002
Henry, Clarke L	Shawnee Mission	125
Henry, Clarke L, Jr	Kansas City	125
Henry, Jos E	Shawnee Mission	050
Henry, Kurt A	University City	215
Henry, Lawrence D	Columbia	058
Henry, Mary M	Kansas City	125
Henry, Roy A	Springfield	082
Henselmeier, Dale M	Bridgeton	190
Henson, Bruce E	Kansas City	125
Henzel, John H	Columbia	026
Herdoiza, Alfonso W	Overland Park	125
Herfkens, Kenneth D	Springfield	082
Herman, Robert L	Kansas City	125
Hernandez, J. Humberto	California	058
Hernandez, Salvador R	St. Louis	190
Herrick, Thomas B	No Kansas City	050
Herrmann, Deborah A	Springfield	215
Herrmann, Virginia M	St. Louis	190
Hershey, Falls B	St. Louis	190
Hertel, Ronald C	St. Louis	190
Hervey, Wm H	Kansas City	125
Heryer, John W	Kansas City	125
Herzog, Godofredo M	Florissant	190
Herzog, Jacques A	Chesterfield	190
Hesker, Albert E	Chesterfield	190
Hess, John P	St. Louis	190
Heutel, Lee B	St Louis	190
*Hevel, Robert W	Palmyra	150
*Hey, Dennis J	Kansas City	125
Hickey, James L	St. Louis	190
Hicks, Frederick G	St. Louis	190
Hicks, Robb R, IV	Cape Girardeau	042
Hicks, Robert S	St. Louis	190
Hierholzer, Rebecca S	No. Kansas City	125
Higgins, Edward F, JR	Kansas City	125
Higgins, Michael D	Cape Girardeau	042
Higgins, Philip C	St Louis	190
Higgins, Ronald A	Kansas City	125
Higgs, Philip E	St. Louis	190
Highland, Thomas R	Columbia	026
Hilbert, Paul H	St. Louis	190
Hildreth, H. Rommel	Bowling Green	190
Hill, Jack H	Leawood	125
Hill, M. Robert	St. Louis	190
Hill, Randy C	Springfield	082
Hill, Ronald T	Dexter	202
Hill, XaCadene A	St. Louis	190
Hills, Joe E	Springfield	082
Hilton, Paul E	Joplin	102
Hinds, Paul A	Springfield	082
Hinds, R. David	Columbia	026
Hindupur, Mohan R	St. Joseph	030
Hink, Frederick W	Independence	125
Hinrichs, James H	St. Charles	190
Hinson, Gary W	Prairie Village	125
Hintze, Paul F	Chesterfield	190
Hironimus, John E	St Louis	190
Hirshberg, Gary E	St. Louis	190
Hite, Dennis E	Lebanon	115
Ho, Grinny H	Sikeston	202
Ho, Judith E	St. Louis	190
Hobbs, John E	Eugene	190
Hodge, Robt H	Kansas City	050
Hodgson, Frank H	Overland Park	125
Hoech, Geo P, Jr.	Kansas City	125
Hoehn, John P, III	St. Louis	190
Hoelscher, Harold F	Warrenton	074
Hoeman, Michael D	Springfield	082
Hoeper, Samuel D, Sr.	Grandview	125
Hoeper, Samuel D, Jr.	Grandview	125
Hof, David G	Kansas City	125
*Hoffman, James E	Cape Girardeau	042
Hoffman, Leanna M	Hamilton	148
Hoffman, Mark J	St. Louis	190
Hoffman, William F	St. Louis	190
Hoffmann, Alan L	Kansas City	125
Hoffmann, Lee M	Shawnee Mission	125
Hoffmann, Ronald E	St. Louis	190
Hoffmann, Sandra S	St. Louis	190
Hofmeister, Roger W	Columbia	026
Hofstatter, Leopold	St Louis	190
Hogan, Cornelius E	St. Louis	190
Hogan, John R	St Louis	190

---

*Doctor of osteopathy.

Hogan, Patrick A	St Louis	190
Hogan, Patrick C	St. Louis	190
Hogue, Charles W, Jr.	Clayton	002
Hoja, John M	Poplar Bluff	034
Hoja, W Alex	Poplar Bluff	034
Holand, Roy W	Springfield	082
Holbrook, C. R. , III	Kansas City	125
Holcomb, John K	Cape Girardeau	042
Holder, Barrett K	St. Louis	190
Holder, Thos M	Overland Park	125
Holds, John B	St. Louis	190
Holekamp, Timothy	Columbia	026
Holemon, R. Eugene	St. Louis	190
Holland, Robt D	Springfield	082
Holleman, David N	Kansas City	125
Holley, Donald B	Camdenton	120
Hollinger, Lloyd A	Shawnee Mission	125
Hollis, Richard W	Springfield	082
Hollo, Vencel W	Clayton	190
Hollocher, Richard J	St. Louis	190
Holloway, Robert B	St. Louis	190
Holmes, David R	Springfield	082
Holmes, Nancy E	St. Louis	190
Holmes, Richard A	Los Angeles	026
Holtmann, Barbel	St. Louis	190
Holtmeier, Douglas L	Festus	106
Holton, Edward B	Independence	125
Holtz, Alan S	St. Louis	190
Holzem, Craig S	Washington	074
Honaas, Trygve O	Cape Girardeau	042
***Honderick, Richard T**	Springfield	082
Honeycutt, Pamela J	Columbia	026
Hong, Diana L	Overland Park	215
Hood, Roger W	Shawnee Mission	125
Hookerman, Bruce J	Bridgeton	190
Hooper, Anthony C	Ballwin	190
Hoos, Gary L	Springfield	082
Hooshmand, Ahmad	Jefferson City	058
Hopkins, James P	Kansas City	125
Hopkins, T. Spencer	Hughesville	178
Hopkins, Thos J	Sedalia	178
Horan, John J, Jr.	St. Louis	190
Horenstein, Simon	St. Louis	190
Horine, Jon A	Kansas City	125
Horn, Paul C	Cape Girardeau	042
Hornbostel, Phillip M	Sedalia	178
Horner, John L	Manchester	190
Hornig, Gregory W	Kansas City	125
Hornstra, Robijn K	Kansas City	125
Horochowski, Alejandro	Sedalia	178
Horton, Bill G	Springfield	082
Horton, James D	Springfield	082
Horwitz, Irwin B	Clayton	190
Hoskins, R. Bruce	Kansas City	125
Hosler, Mark W	Cape Girardeau	042
***Hosley, Brett D**	St. Louis	215
Houck, William E	St. Louis	190
Houghton, Howard L	Kansas City	125
Houttuin, Erik	Washington	106
Hover, Alexander R	Springfield	082
Howard, Campbell P	Kansas City	125
Howard, Richard J	Blue Springs	002
Howell, Billy D	Brookfield	078
Howell, David T	Florissant	002
Howitt, William J	Springfield	082
Hoxworth, Gerald M	Belle	014
Hoye, Robert C	Ste. Genevieve	174
Hrabik, Brent	Tarkio	158
Hruska, Keith A	St. Louis	190
Hruza, George J	St. Louis	190
Hsu, Cecilia C	Overland Park	125
Hu, Raymond J	St. Peters	189
Hubbard, Sally L	Springfield	082
Hubbell, George P	Osage Beach	120
Hubbell, Marius M, Jr.	Kansas City	125
Hubert, John W	Bridgeton	190
Hubert, John P, Jr.	Ashland	190
Huck, Richard F, Jr.	St Louis	190
Huckstep, Robt A	Farmington	138
Huddleston, Charles B	St. Louis	190
Hudgens, Richard W	St. Louis	190
Hudson, Randall B	Kansas City	125
Huewe, Douglas A	Springfield	082
Huff, Kalaichelvi R	Joplin	102
Huffaker, William H	Chesterfield	190
Huffman, Thos L	Branson	208
Hufft, Robert E, Jr	Springfield	082
Huggins, Albert M	St Louis	190
Hughes, Derek	Columbia	026
Hughes, Judson M	St. Joseph	030
Hughes, Michael F	Kansas City	125
Hughes, Robt G	St. Louis	190
Hughes, W. Steven	Columbia	215
Huk, Stephen G	N. Kansas City	050
Hulbert, Bernard	St Louis	190
Hulbert, Laura R	St. Louis	190
Hull, Timothy A	Kansas City	125
Hulstra, Johannes F	Springfield	082
Hummel, Anton J	St Louis	190
Humphrey, James D	Mound City	158
Humphrey, Loren J	Columbia	026
Humphrey, Paul W	Columbia	215
Humphreys, Edward T	Boonville	026
Humphreys, William	St. Joseph	030
Hunkeler, John D	Kansas City	125
Hunleth, Frank E	St. Louis	190
Hunsley, Perry U	Branson	208
Hunt, Robert S	Cape Girardeau	042
***Hunter, Harlen C**	Chesterfield	190
Hunter, James K, Jr.	Fairfax	158
Hunzicker, Warren J	Kansas City	125
Huq, MD N	Mexico	014
Hurley, Joseph J	St. Louis	190
Hurley, Martha L	Blue Springs	125
Hurly, Michael P	Joplin	102
Husain, S. Arshad	Columbia	026
Huse, William J, II	Kansas City	125
Hustead, Russell M	Shawnee Mission	125
Husted, Frederick C	Springfield	082
Huster, Robert M	Rolla	135
Huston, Kent A	Kansas City	125
***Hutchins, Sherry S**	Savannah	030
Hutchinson, William B	St Louis	190
Hyde, Lawrence L	Kansas City	125
Hyde, Rita M	Kansas City	125
Hyers, Thomas M	St. Louis	190

I

Iacobucci, John J	St. Louis	002
Icaza, Ramiro	Jackson	042
Ide, Carl H	Columbia	026
Ide, Lucien W	St Joseph	030
Idstrom, Mark E	Kansas City	125
Ikeda, Shigemasa	St. Louis	190
Imes, Elvin D	Columbia	026
Inciardi, Marc F	Kansas City	125
Ingham, Walton C	Shawnee Mission	125
Ingram, Donald R	Crystal City	190
Inman, Max M	Chesterfield	190
Inniss, Rosalyn E	Kansas City	125
Ip, Aidan W	St. Louis	190
Ippensen, John H	Springfield	082
***Irinyi, Elmer T**	Gower	030
Irvin, William S	Columbia	026
Irvin, Wm M	St Louis	190
Irwig, Fred	Overland Park	125
Isaac, Anita M	Springfield	166
***Isaacs, Victor E**	Scott City	042
Ishida, Yasuo	St Louis	190
Ittner, Geo W	St. Louis	190
Ivins, Gregory K	Fulton	038
Iwane, Akira	Chesterfield	190
Iyer, Manny S	Kansas City	125
Izmirlian, Grant	St. Louis	190

J

Jaax, Jeffrey D	Kansas City	125
Jablonski, Raymond C	St. Louis	190

---

*Doctor of osteopathy.

*Jacks, Richard K	St. Joseph	030
Jackson, Darwin C	Florissant	190
Jackson, Dorothy J	Blue Springs	125
Jackson, Jay A	Kansas City	125
Jackson, Mary Anne	Kansas City	125
Jackson, Max G	Kansas City	125
Jackson, Roger P	Kansas City	050
Jackson, Vernon B	Fulton	038
Jacob, Karl A	St Louis	190
Jacob, Kenneth M	Kansas City	125
Jacobs, Chas C	St. Louis	190
Jacobs, Morton	Shawnee Mission	125
Jacobs, Walter H	Kansas City	125
Jacoby, Michael R.K.	Kansas City	125
Jaeger, Jos N	Jackson	042
Jahanian, Iraj	Springfield	082
Jain, Savitri G	St. Louis	190
Jain, Sumer C	St. Louis	190
Jamaluddin, Mohideen A	Festus	106
James, Elizabeth J	Columbia	026
James, Kathleen M	St. Charles	189
James, Otis E	Shawnee Mission	125
James, Ronald C	Columbia	026
Jameson, James E	Springfield	082
Jamroz, Greg A	Washington	074
Jamry, Wit A	St. Louis	215
Janeczko, Gregory F	Springfield	082
Jantsch, Deborah A	Kansas City	125
Jantz, Keith	Kansas City	125
Jarvis, Cathy C	Florissant	190
Jary, Mark L	Ozark	082
Jatala, Ijaz A	Granite City	190
Javdan, Ron	Chesterfield	190
Jayamanne, Damasus S	Jefferson City	058
Jayanandaiah, Hiremathada	Hannibal	150
Jedlinski, Michael T	Cape Girardeau	042
Jefferis, Kenneth R	Maryville	158
Jeffries, Joel T	Columbia	026
Jelley, V. Carl	Blue Springs	125
Jenkins, David C	Kansas City	125
Jenkins, Edward R	Waynesville	135
Jenkins, James J	St Louis	190
Jennett, J H	Kansas City	125
Jennett, Richard B	Jefferson City	058
Jensen, Joshua E	Lake Sherwood	190
Jensen, Joshua E, II	St. Louis	190
Jernstrom, Vance R	Kansas City	125
*Jibben, Bobby J	Sikeston	202
Jobe, Chas L	Springfield	082
Johans, Thomas G	St. Louis	190
Johnson, C. L.	Kansas City	125
Johnson, Charles J	St. Louis	190
Johnson, Chas S	Warrensburg	110
Johnson, Cynthia K	Kansas City	215
Johnson, Dallas A	Overland Park	125
Johnson, Darry S	Kansas City	215
Johnson, E D, III	Cape Girardeau	042
Johnson, Earl W	Cape Girardeau	042
Johnson, Frank E	St. Louis	190
Johnson, Fritz M	Springfield	082
Johnson, Gareth R	Independence	125
Johnson, Garry A	Manchester	190
Johnson, Glen E	St. Louis	190
Johnson, Gordon L	Festus	106
Johnson, James S	Kansas City	125
Johnson, Jeffrey R	Springfield	082
Johnson, Jonathan H	Poplar Bluff	034
Johnson, Jos C, Jr	Springfield	082
Johnson, Joseph E	Kansas City	125
Johnson, Joy A	Kansas City	125
Johnson, Kelly L	Shawnee Mission	215
Johnson, Lent C	Hannibal	150
Johnson, Lenworth N	Columbia	026
Johnson, Michael K	St. Louis	190
Johnson, Randy G	St. Louis	190
Johnson, Rebecca S	Kansas City	125
Johnson, Richard E	Columbia	026
Johnson, Richard L	Kansas City	125
Johnson, Robert D	Springfield	082
Johnson, Steven M	St. Louis	190
Johnson, Thos M	Shawnee Mission	125
Johnson, Warford B, Sr	Springfield	082
Johnson, Warford B, II	Springfield	082
Johnson, Warren L, JR	Kansas City	125
Johnson, Wm F	Springfield	082
Johnston, Glen P	Bonne Terre	190
Johnston, Richard	St. Louis	190
Johnstone, John T	St. Louis	190
Jolly, Ben L	Mexico	014
Jolly, Benj N	Mexico	014
Jonas, Harry S	Chicago	125
Jones, Bruce N	Chesterfield	190
Jones, Dorothy J	St. Louis	190
Jones, Edna M	Deepwater	086
Jones, Edward S	Overland Park	214
Jones, Elizabeth A	Shawnee Mission	125
Jones, Gale O	Kansas City	125
Jones, Georgia A	St. Louis	190
Jones, Harold L	Springfield	082
Jones, Jeffrey T	Joplin	102
Jones, Keith D	Warrensburg	110
Jones, Laird E	Springfield	082
Jones, Lowry , Jr.	Kansas City	125
Jones, Maynard C, Jr.	Kansas City	125
Jones, Michael D	Mexico	014
Jones, Patricia E	Kansas City	125
Jones, Paul S	Joplin	102
Jones, Randall W	Independence	125
Jones, Richard A	St. Louis	190
Jones, Robert W	West Plains	206
Jones, Robert P	Blue Springs	125
Jones, Robert R	Nevada	214
Jones, Robin R	Columbia	026
Jones, Stanley G, Jr.	Sikeston	202
Jones, T. Reid	Shawnee Mission	125
Jones, Timothy R	St. Louis	190
*Jordan, Earl L, Jr	Joplin	102
Joslyn, Harold L	Mt Vernon	190
Jost, Charles A	N. Ft. Myers	190
Jost, R. Gilbert	St. Louis,	190
Jotte, Randall S	Kirkwood	002
Jotte, Richard P	St. Ann	190
Jotte, Richard F	St. Louis	190
*Joubert, Paul M	Lee's Summit	125
Joyce, Rex M	Kansas City	125
Joyce, Steven T	Kansas City	125
Judd, Donald R	St. Louis	190
Judd, Jeffrey B	St. Louis	190
Judge, Mark A	Seattle	102
Judge, Steven J	Washington	074
Judge, Walter T	Crystal City	106
Judy, Joseph D	Beloit	026
Juergens, Wm G	St Louis	190
Julien, Rene	St. Louis	190
Jung, Christopher H	Cape Girardeau	042
Jung, J. Marshall	Cape Girardeau	042
Junker, James A	St. Louis	106
Justus, John B	Shawnee Mission	125

K

Kagan, Stuart M	Shawnee Mission	125
Kahn, Joseph A	St. Charles	189
Kahn, Marvin	Kansas City	125
Kairuz, Bartolome C	St. Louis	190
Kaiser, George C	St. Louis	190
Kaiser, Larry R	Philadelphia	190
Kakaiya, Dilip H	Kennett	070
Kakaiya, Ram M	St. Louis	002
Kallenbach, Glen P	Mexico	014
Kamada, Tsutomu	O'Fallon	189
Kamakas, Nicholas C	Florissant	190
Kamath, K.P.S.	Cape Girardeau	042
Kamenetzky, Stephen A	St. Louis	190
Kaminski, Donald L	St. Louis	190
Kampfe, Paul W	St. Charles	189
Kanagawa, Harold K	Jefferson City	058
Kanarek, Joseph	Kansas City	125
Kang, Juan	St Louis	190
Kang, Young M	West Plains	206

---

*Doctor of osteopathy.

Kanne, Marty A	Kansas City	050
Kantor, Julius M	Mission Hills	125
Kantor, Owen	St Louis	190
Kantor, Samuel	Englewood	125
Kapitan, Kent S	Kansas City	125
Kaplan, Alex H	St Louis	190
Kaplan, Henry J	St. Louis	190
Kaplan, Michael F	Columbia	026
Kappesser, Netajean G	St Louis	190
Kappesser, Roland C	St Louis	190
Kardesch, Milton	St. Louis	190
Karl, Michael M	St. Louis	190
Karraker, Alvan G	Farmington	138
Karsh, Robt S	St Louis	190
Kartus, Irving	Shawnee Mission	125
Kase, James B, Jr.	Kansas City	125
Kass, Michael A	St. Louis	190
Kasten, Mark C	Cape Girardeau	042
Kasten, Melvin C	Cape Girardeau	042
Kasten, Ex.Sec., Mrs. Lois	Cape Girardeau	001
Katf, Nicola Y	N. Kansas City	050
Katsantonis, George	St. Louis	190
Kauffman, Ruth	Versailles	120
Kaufman, Andrew B	Kansas City	125
Kaufman, Bruce A	St. Louis	190
Kaufman, Robt L	St Louis	190
Kaufmann, Herbert H	Kansas City	125
Kauk, Bruce A	N Kansas City	050
Kaup, Chandra S	Florissant	190
Kayanan, Jose C	Kansas City	125
Kayes, Jack	St Louis	190
Kays, Kenneth M	Moberly	046
Keairnes, Harold W	Kansas City	125
Keating, James P	St Louis	190
Keay, Myoung Soo	Chillicothe	078
Keefe, David M	St Charles	189
Keesal, Dennis	St. Charles	189
Keitges, Pierre W	Overland Park	125
Keleti, Daniel	St. Louis	215
Keller, Barbara P	Columbia	026
Keller, Maurice J	St Louis	190
Keller, Robt M	Wentzville	189
Keller, Stephen M	St. Louis	190
Kellett, John G	St. Louis	190
Kelley, Gilbert B	Savannah	010
Kelling, E. Collyer	Springfield	082
Kelly, Charles R	Kansas City	125
Kelly, John J	St Louis	190
Kelly, John B	Joplin	102
Kelly, Joseph G	No. Kansas City	050
Kelly, R E	St Louis	190
Keltner, Raymond O	Kansas City	125
Keltner, Raymond M, Jr.	St. Louis	190
Kemp, Michele E	Chesterfield	190
Kendall, Charles A	Independence	125
Kendall, Forrest H	Kansas City	125
Kendis, Joseph B	St. Louis	190
Kenneally, Cynthia Z	St. Louis	190
Kennedy, David G	St. Louis	190
Kennedy, Timothy D	Overland Park	125
Kennett, Jerry D	Columbia	026
Kenney, Douglas R	Clinton	086
Kenney, John D, III	Kansas City	125
Kenney, John D	St. Louis	190
Kenney, Roy E	Neosho	166
Kensel, Robert S	Springfield	082
Kent, Bela K	Shawnee Mission	125
Keohane, Mark	St Charles	189
Kerkemeyer, George	Hannibal	150
Kerley, Spencer W	Overland Park	125
Kerr, Harold H	Shalimar	125
Kessel, James W	St Louis	190
***Kesseler, Randall G**	Springfield	082
Kessler, William D, Jr.	Joplin	102
Kesssinger, William A	Springfield	082
Ketcherside, W. Joseph	Liberty	050
Ketterman, Grace H	Kansas City	125
Key, James S	Springfield	082
Khalil, Tamer G	Springfield	082
Khan, Abdul G	Arnold	190
Khan, Altaf A	St Louis	190
Khan, Khalid I	Cape Girardeau	042
Khojasteh, Ali	Columbia	026
Khojasteh, Saaid	St. Louis	190
Khouri, Roger K	St. Louis	190
Khoury, Cecile S	Leawood	125
Khurana, Satish K	Lenexa	125
Kiburz, Douglas W	Sedalia	178
Kiekhaefer, Theodore C	St. Joseph	030
Kienzle, Edward	Bonne Terre	190
Kies, Richard L	Cape Girardeau	042
Kilbride, Howard W	Kansas City	125
Kilgore, John W	St. Louis	190
Killen, Duncan A	Kansas City	125
Killion, Linza T	Kansas City	125
Kilo, Charles	St Louis	190
Kim, Chul	Poplar Bluff	034
Kim, Harold H	St.Louis	002
Kim, Joo H	Kansas City	215
Kim, S. Brian	Springfield	082
Kim, Stanley W	St. Louis	190
Kim, Tae S	Crystal City	106
Kim, William W	St. Louis	190
Kim, Yang H	Washington	074
Kim, Yong Kie	Cape Girardeau	042
Kimball, Merritt H	Colorado Spgs	125
Kimble, Harvey S	Kansas City	125
Kimbrough, Robert C, III	Springfield	082
Kime, Ricky L	Cassville	166
Kimelman, Nathan	St Louis	190
Kimlinger, William R	Jefferson City	058
Kincaid, Rosa A	Sikeston	202
Kinder, Doyle O	Springfield	082
Kinder, James A	Cape Girardeau	042
Kinder, Jerry L	Cape Girardeau	042
Kindred, Lynn H	Kansas City	125
King, Dana M, III	St. Joseph	030
King, Donald K	St. Louis	190
King, Eustace E, III	Chesterfield	190
King, Francis C	St. Louis	190
King, Frank K	Hayti	170
King, Gregory S	St. Louis	190
King, J. Tenbrook	Prairie Village	125
King, John V, Jr.	Ballwin	190
King, John V, Sr.	St Louis	190
King, M. Kenton	St. Louis	190
King, Mark D	St. Louis	215
King, Richard H	Clinton	086
King, Robert J	Columbia	026
King, Robert W	Rolla	135
Kingsbury, Helen	Shawnee Mission	125
Kingsbury, Robt J	St. Peters	189
Kingsland, Robert C	Sarasota	190
Kinney, Janet S	Kansas City	125
Kinsella, Edward D	St. Louis	190
Kinsella, Peter W	St. Louis	190
Kinsella, Ralph A, Jr.	St. Louis	190
Kipfer, Robt E	Springfield	082
Kipnis, David M	St Louis	190
Kiridly, Nabil K	Lenexa	215
Kirkland, Jerry A	Kansas City	050
Kissane, John M	St. Louis	190
Kissel, John H	St. Louis	190
Kissell, Richard W	Springfield	082
Kister, Geo E	St. Charles	189
Kistler, W. David , Jr.	St. Louis	190
Kitchen, Alice D	St. Louis	190
Kiyanclar, M. Emin	St. Louis	190
Klachko, David M	Columbia	026
Klearman, Debra J	St. Louis	215
Klearman, Micki	St. Louis	190
Klein, Edward H	Shawnee Mission	125
Klein, Kendel L	Mt. Vernon	166
Klein, Saul J	St. Louis	190
Kleinschmidt, Donn C	St. Louis	190
Kleopfer, Lynn L	Moberly	046
Kletzker, George R	St. Louis	190
Kline, Carlyn M	St Joseph	030
Kline, Edmund W	St. Joseph	030
Kline, James	St. Joseph	030

---

*Doctor of osteopathy.

Klingner, Geo M, Jr	Springfield	082
Klinkerfuss, Geo H	Springfield	082
Klippel, Allen P	St. Louis	190
Knabb, Henry F, Jr	Springfield	082
Knabb, Kenneth E	Springfield	082
Knapp, Jane F	Kansas City	125
Knepper, Paul A, III	St. Joseph	030
Knight, Franklin P	St. Louis	190
Knight, James W	St. Louis	190
Knight, Wm A, Jr.	St Louis	190
Knipschild, Bedford F	Marshall	198
Knoch, H. Kermit	Shawnee Mission	125
Knock, Henry L	St. Louis	190
Knopf, Harry L	St. Louis	190
Knowles, R. Raymond	Webster Groves	190
Knowlton, Norman P, III	Springfield	082
Knudsen, Michael W	St. Louis	215
Knudson, Dennis R	Columbia	026
Kobbermann, Kobby J	Springfield	082
Kobbermann, Thomas W	Liberty	050
Kodner, Ira J	St Louis	190
Koehler, Geo A	St. Louis	190
Koehn, Douglas P	Marshall	198
Koenig, Gary D	Florissant	190
Koenig, Marvin I	St. Louis	190
Koerner, Kenneth A	St. Louis	190
Kofkoff, Richard L	Bridgeton	190
Kohler, Roy	Springfield	082
Koivunen, Debra G	Columbia	026
Kolda, Michael A	Cape Girardeau	042
Kolker, Allan E	St. Louis	190
Kolze, Vernon W	Springfield	082
Koon, Benny H	Bolivar	066
Koontz, Kenneth L	Kansas City	125
Koontz, Paul G	Kansas City	125
Kopelson, Jeffrey C	Ossining	190
Kopp, Kenneth R	Lenexa	125
Kopp, Shelby K	St. Louis	190
Koppers, Lawrence E	Kansas City	125
Korenblat, Phillip E	St. Louis	190
Korn, Robert L	St. Louis	190
Kort, Arthur A	St. Louis	190
Kory, Steven M	Louisville	215
Kotner, Lawrence M, Jr.	St. Louis	190
Kotner, Lawrence M, Sr.	St. Louis	190
Kouchoukos, Nicholas T	St. Louis	190
Kouo, Louis	Cape Girardeau	042
Kovac, S. Robert	St Louis	190
Kowert, Edward H	Kirkwood	190
Kozminski, Mike	St. Joseph	030
Kraeger, Russell R	St Louis	190
Kraemer, Bruce A	St. Louis	190
Kraetsch, Robert E	St Louis	190
Kraft, Jacob	Kansas City	125
Krahn, Henry C	Springfield	082
Krain, Samuel	St Louis	190
Krajcovic, David P	Chesterfield	190
Kramer, Jeffrey B	Prairie Village	125
Kramer, Robert S	St. Louis	190
Kraner, Justin F	St. Louis	190
Kranson, Seymour J	Hemet	125
Kratz, Paul E	Cape Girardeau	042
Kraus, Frederick T	St Louis	190
Krause, G. Lynn , Jr.	Chesterfield	190
Krautmann, John J	Jefferson City	058
Kraybill, William G	St. Louis	190
Krebs, Festus J, III	Kansas City	125
Krechel, Susan W	Columbia	026
Kreisman, Jerold J	St. Louis	190
Kreski, Kenneth C	House Springs	190
Kretchmar, Alan P	St Louis	190
Krettek, John E	Chesterfield	190
Kreusser, Katherine L	St. Louis	190
Krewet, Frank A, III	St Louis	190
Kriegshauser, Lawrence A	St. Louis	190
Krishna, Padma	Kansas City	125
Kroeger, Geo B, Jr.	St. Louis	190
Kroetz, Frank W	Sikeston	202
Krojanker, David N	St. Louis	190
Krojanker, Rolf J	St Louis	190
Kromer, Chas J	St Louis	190
Kronemer, Keith A	New Orleans	215
Kronemer, Norton S	St. Louis	190
Krug, Paul E	Kansas City	125
Krummenacher, Thomas K	St. Louis	190
Kruse, Carl R	Palmyra	150
Kryshak, Edward J	Springfield	082
Kuangparichat, Manoch	Excelsior Spgs.	118
Kuebel, Richard J	St. Louis	190
Kuenzi, Donald E	Kansas City	050
Kuhlman, Ralph F	St Louis	190
Kuhlman, Robert E	St Louis	190
Kuhn, Lawrence F	St. Louis	190
Kulak, Gary	St Louis	190
Kulkarni, Nandini S	St. Louis	190
Kulkarni, Satish R	Town & Country	189
Kumari, Vijaya	St. Louis	190
Kunst, Edward J	Ballwin	190
Kunz, Stephen R	Overland Park	125
Kuo, Gong T	Kennett	070
Kurtz, Karl J	Kansas City	125
Kwoun, Soung O	Bridgeton	002
Kyger, John E	Independence	125

L

L'Ecuyer, Jerome L	St Louis	190
Laatsch, Robt H	Poplar Bluff	034
Labayen, Ricardo A	Overland Park	125
LacKamp, Robert J	St. Joseph	030
Ladd, Charles B	St. Louis	190
Ladenson, Roland P	Columbia	026
Laguerre, Max S	N. Kansas City	002
Lai, Hsien-Ell	Higginsville	118
Lai, Jacqueline Ya C	Kansas City	215
Laird, John M	St. Louis	190
Lakusiewicz, Ronald J	Poplar Bluff	034
Lally, James J	Shawnee Mission	125
Lamb, Eileen	St. Charles	189
Lamb, Jerome P	Blue Springs	125
Lamb, Wanda	St. Louis	190
Lamberti, Jos W	Columbia	026
Lampert, Benjamin A	Springfield	082
Lamping, J. Daniels	St. Louis	190
Lampros, William P	St. Louis	190
Lampton, Lawrence M	Columbia	026
Lamy, John E	Sedalia	178
Landau, David W	St. Louis	190
Landau, Wm M	St. Louis	190
Landers, Burnell	Kansas City	125
*Landers, Gary A	N Kansas City	050
*Landers, Milton H	St. Joseph	030
Landhuis, Leo R	Columbia	026
Landis, Geo K	Raymore	125
Landman, Danielle	St. Louis	215
Landrum, Alice L	Columbia	026
Landsbaum, Charles J	Jefferson City	058
Landsman, Ira S	Kansas City	215
Landy, Richard	St. Louis	190
Lane, Charles A	Hannibal	150
Lane, Daniel K	St. Louis	190
Lang, John J	St Louis	190
Lange, David R	Bridgeton	190
Langley, Harriet S	Kansas City	125
Lankford, Harold D	Mexico	014
Lansche, W. Edward	St. Louis	190
Lapi, Angelo	Shawnee Mission	125
Laposky, Lynda L	Chesterfield	190
Lappas, Demetrios G	St. Louis	190
Laramore, Rosemary	Columbia	026
Larsen, Wm E	Shawnee Mission	125
Larson, Paul U	St Louis	190
Lass, Nancy A	Brentwood	190
Latham, Raymond W	Kansas City	125
Latif, Azhar	Lexington	118
Latimer, Walter N	Gladstone	050
Lattinville, Henry E	Bridgeton	190
Lauber, Joseph J	St Louis	190
Lauderdale, William H	Forsyth	208
Lauer, Danl J	Kansas City	125

---

*Doctor of osteopathy.

Lauer, John D	St. Louis	190
Laughlin, Edward J	Independence	125
Laughlin, Thomas P	Kansas City	125
Laux, France A	St. Louis	190
Lawrence, Willie E, Jr.	Kansas City	125
Lawton, John T	St. Louis	190
Layle, John K, Jr.	Kansas City	125
Layton, Ira C	Shawnee Mission	125
LaBach, James P	Overland Park	125
LaDriere, Raymond J	St. Louis	190
LaFerriere, Keith A	Springfield	082
LaFoe, William K	Cape Girardeau	042
LaHue, William C	Lexington	118
LaMear, William R	Columbia	215
LaMonda, Gary W	Columbia	026
LaPietra, Martha M	Lee's Summit	125
Le, Van A	St. Louis	215
Leary, Daniel J	St. Louis	190
Lederer, Charles M, Jr.	Kansas City	125
Lederer, Chas M, Sr	Warrensburg	110
Lednicky, Jay A	Lee's Summit	125
Lee, David Y S	Cape Girardeau	042
Lee, Fransiska A	St. Louis	190
Lee, Gerald B	Kansas City	214
Lee, H. T.	Columbia	026
Lee, Henry A	Leawood	125
Lee, Joseph King Tak	St. Louis	190
Lee, Jung H	Crystal City	106
Lee, King Y	Kansas City	125
Lee, Leander K	St. Louis	190
Lee, Tae H	Leawood	125
Lee, Wilfred	Cape Girardeau	042
Leech, Maurice P	Green Valley	026
Leeper, Claude K	Columbia	026
Leeper, Sidlee W	Rocheport	026
Leese, Philip T	Lenexa	125
Legarda, Maria M	Kansas City	125
Legler, Larry E	Independence	125
Lehman, Richard C	St. Louis	190
Lehman, Robert B	St. Louis	190
Leibsohn, Joel M	Independence	125
Leidenfrost, Ronald D	Chesterfield	190
Leifer, Gary	Kansas City	125
Leifer, William W	Kansas City	125
Leiferman, James G	St. Louis	215
Leightner, William F	St. Louis	190
Leitch, Steven M	Springfield	082
Lem, Vincent M	Kansas City	125
Leming, Bert H	St. Louis	190
Lenobel, Milton I	Longboat Key	190
*Lensgraf, S. Jay	Sedalia	178
Lents, Rickey L	Cape Girardeau	042
Lentz, Clark H	Shawnee Mission	125
Lentz, Harold C	Neosho	166
Lentz, Harold C, Jr.	Independence	125
Lentz, Kathy J	Washington	074
Lenzenhuber, Karl J	Washington	074
Lepkowski, Hemlata K	Columbia	026
Lepkowski, Marek B	Columbia	026
Lerner, Bruce	Independence	125
Lerner, Scott A	Kansas City	125
Leroux, Gene H	Doniphan	034
Lerwick, Everett R	St Louis	190
Leslie, James T	Jefferson City	058
Leslie, Stephen A	Kansas City	050
Letizia, Wayne L	Independence	125
Levanvo, William	Joplin	102
Levenson, Ernest	Poplar Bluff	034
Levenson, Ina	Poplar Bluff	034
Levi, Bernard	Kansas City	125
Levie, Benton B	Sikeston	202
Levin, Marvin E	Chesterfield	190
Levine, Laurence A	St. Charles	190
Levine, Richard S	St. Louis	190
Levitt, Joseph	St. Louis	190
Levitt, Robert G	St. Louis	190
Levy, Jerome F	St Louis	190
Levy, Morton A	St. Louis	190
Lewandowski, Molly J	Leawood	125
Lewin, W. Howard	St. Louis	190
Lewis, David M	Sikeston	202
Lewis, J. Eugene	St. Louis	190
Lewis, Lawrence M	St. Louis	190
Lewis, Matthew T	Jefferson City	058
Lewis, Noel R	Springfield	082
Lewis, Revis C	Kansas City	125
Lewis, Robert D	St. Louis	190
LeBlanc, Leo J	Clayton	190
LeFevre, Philip J	Springfield	082
Liang, Jing C	Independence	125
Liao, Kun T	St. Louis	190
Libel, Roy D	Springfield	082
Lichtor, Jos M	Kansas City	125
Lichty, Chas A	Shelbina	150
Lieb, Francis X	Richmond	190
Lieb, Thomas F	Clayton	190
Lieberman, David M	St Louis	190
Liebhaber, Harvey	St Louis	190
Lightfoot, Ben D	Westwood Hills	215
Lila, Aram	Excelsior Spgs.	050
*Lillig, James F	Kansas City	050
Lilly, Douglas R	St Louis	190
Lim, Piemsak	Bridgeton	190
Lima, Jose A	St. Louis	190
Limmer, Byron L	Columbia	215
Limpiphiphatn, Dhajphong	Perryville	174
Limpiphiphatn, Ester P	Perryville	174
Lin, C H	Moberly	046
Lin, Chi-Hsi	Springfield	082
Lin, H T	Moberly	046
Lin, Hsiu-San	St. Louis	190
Linde, John W	Rolla	135
Lindeman, John F	Chesterfield	190
Lindgren, Carleton J	Independence	125
Link, Alexander J	St Louis	190
Link, Vance E	Independence	125
Linsenmeyer, Charles M	St Charles	189
Lintecum, Frederick B	Kansas City	125
Linville, Howard E	Shawnee Mission	125
Lipschitz, Ervin	St Louis	190
Lipsitz, Ellis S	St. Louis	190
Lischwe, Daniel H	Bridgeton	190
Liss, Jay L	St Louis	190
*Little, Patrick T	Hayti	170
Littlejohn, Robert T	N Kansas City	050
Litton, Lyle D	Springfield	082
Litton, Lynn O	Prairie Village	026
Litton, Nancy J	Independence	125
Litwiller, Raymond W	Canada V8R6T2	026
Litzow, Peter L	St. Louis	190
Liu, Ben C	Kansas City	125
Livingston, Don G	Ballwin	190
Llana, Angelo A	St. Joseph	030
Llorens, Alfred S	Columbia	026
Lobdell, Creig M	Springfield	082
Lockard, Orlyn O	St. Joseph	030
Lockhart, Charles E	Springfield	082
Lockwood, Gary F	Kansas City	125
Lockwood, Ted E	Overland Park	125
Loeb, Richard H	Springfield	082
Loeb, Virgil , Jr.	St. Louis	190
Loeffel, Ellen S	St Louis	190
Loeppky, Carol B	Columbia	026
Loesch, J. John	Joplin	102
Lofgreen, Craig S	Kansas City	125
Loftus, Loretta S	Kansas City	125
Logan-Morrison, Beverly A	St. Louis	190
Loggan, Michael B	Liberty	050
Logie, Macdonald B	St. Louis	190
Logue, John T	Columbia	026
Lohmar, Roland E	Columbia	026
Lohr, Robert W	St. Louis	190
Lohrentz, Lois H	Shawnee Mission	125
Loitman, Bernard S	St Louis	190
Lombardo, Joseph A	St. Louis	190
Lombardo, Richard J	Springfield	082
Londe, Alan M	St. Louis	190
Londe, Sol	Northridge	190
London, Stanley L	St. Louis	190
Lonergan, James H	Kansas City	125

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*Doctor of osteopathy.

Lonergan, Warren M	Chesterfield	190
*Long, Chester I	Joplin	102
Long, Curtis W	Butler	214
Long, Edwin T	Columbia	026
Long, Frank B	Chesterfield	190
Long, John W	Columbia	026
Long, Priscilla E	Hannibal	150
Long, R. Stacy	Kansas City	125
Long, Stephen E	Springfield	082
Long, Timothy P	Marthasville	074
Long, W. Steven	St. Joseph	030
Lonsway, Maurice J, Jr.	St. Louis	190
Loomis, James F	St. Louis	190
Lopate, Glenn	St. Louis	215
Lopez, Marvin J	St. Louis	190
Lopez, Ruben E	Hayti	170
Lopez-Plata, Roberto	Kansas City	125
Lord, Richard E	St. Louis	190
Lorei, John M	Parkville	002
Loren, Michael L	Independence	125
Lorenc, Ernest	Springfield	082
Lorenzo, Edilberto B	Kansas City	125
Loth, Timothy S	St. Louis	190
Lottes, J. Otto	St Louis	190
Loughead, John R	Poplar Bluff	034
Loutzenhiser, James K	Kansas City	125
Love, Gerry A	Liberty	125
*Loveland, Richard D	Hollister	208
Lovinger, Warren C, Jr.	Nevada	214
Lovinggood, J. Perry	Bridgeton	190
Lovinggood, Thos A	Cape Girardeau	042
Lowe, Alvin L	Sedalia	178
Lowe, H. Arch , Jr	Springfield	082
Loyd, Earl L	Holts Summit	058
Loynd, Robt C	St. Louis	190
Lubniewski, Anthony J	St. Louis	190
Lubowitz, Herbert	St. Louis	190
Lucas, Thomas G	St. Louis	190
Luckenbill, Paul T	Park Rapids	054
Ludwig, Mark A	St. Louis	190
Ludwig, William D	Springfield	082
Ludwikosky, Mikel A	Lee's Summit	125
Luechtefeld, Frank	Florissant	190
Lueckenhoff, Rebecca R	Jefferson City	058
Luerding, Jeffrey A	Kansas City	050
Luetje, Charles M	Kansas City	125
Lugo, Saml	St Louis	190
Luh, Andrew M	St. Louis	190
Luke, Robert A	St. Louis	215
Lund, Herluf G, Jr.	Glendale	190
Lund, Herluf G	St. Louis	190
Lund, Robert H, Jr.	Chesterfield	190
Lundgren, Craig H	St. Louis	215
Lundman, Hugh	Springfield	082
Lurie, Harold H	Springfield	082
Lusk, Chas A	Butler	214
Luther, George A	St Louis	190
Lutkewitte, Jos F	Ste Genevieve	174
Luzecky, Michael H	Springfield	082
Lyddon, Harold R, Jr.	Kansas City	125
Lyle, Robt R	Versailles	120
Lyles, Rodney	Overland Park	125
Lyman, Edward H	Clayton	190
Lynch, Gerald C	Kansas City	125
Lynch, Thos W	Springfield	082
Lyons, Daniel F	Springfield	082
Lyskowski, Maria M	Jefferson City	058
Lyss, Carl A	St. Louis	190
Lyss, Stanley B	St Louis	190
Lytle, Edwin L	St. Louis	190
Lytle, Michael F	Mission Hills	125

M

Maben, Sam E	Kansas City	125
Macdonnell, Thos M	Marshfield	210
Machefsky, Sidney D	St. Charles	190
Machek, Otakar	St Louis	190
Mackey, Richard L	St. Louis	190
Maclaughlin, James C	Joplin	102
Macleod, Angus	St Louis	190
Macler, Henry H, Jr.	St. Louis	190
Macnish, James M	St Louis	190
MacDonald, Robin R	Kansas City	125
MacDonald, Robt R, Jr.	St Louis	190
MacDonald, Wm C	St Louis	190
MacGee, Edwin E	Kansas City	125
MacKinnon, Susan E	St. Louis	190
MacNaughton, Ralph E	Kansas City	125
MacNaughton, Robert A, II	Liberty	050
MacNaughton, Robert A	Kansas City	125
Madaj, Debra K	Gladstone	215
Madden, Michael L	Kansas City	002
Maddipati, Sreedezi	St. Louis	190
Madduri, Aruna D	Poplar Bluff	034
Madduri, Sivaprasad D	Poplar Bluff	034
Madlang, Rudy G	Columbia	026
Madrid, Dominador O	St Louis	190
Magaw, David C	Everton	066
Magee, Robt L	Eldorado Spring	214
Magee, W. Edwin	St Louis	190
*Magill, William S	Springfield	082
Magruder, Lyell M	Nevada	214
Mahboubi, Aziz O	Sikeston	202
Maher, Robt W	Springfield	082
Mahmoud, Said F	Kansas City	125
Mahnken, Robert F	Springfield	082
Mais, Thomas E	Kansas City	125
Maitz, Carlos A	St. Ann	190
Major, Troy E	Springfield	082
Majors, Patrick F	St. Louis	190
Majure-Lees, Joyce E	Stilwell	125
Majzoub, Hish S	Joplin	102
Makos, Mignon M	St. Joseph	030
Maliszewski, James A	Kansas City	125
Malkoff, Marc D	St. Louis	190
Mallouk, Alexander G	Kansas City	125
Mallow, James E	Kansas City	125
Malmberg, Virgil L	Chesterfield	190
Maloney, Robert M	St. Louis	190
Maminta-Streiff, Maria G	St. Louis	190
Manansala, Antonio Q	St. Louis	190
Mandler, George	Chillicothe	078
Mangalat, Narayanan K	Joplin	102
Mangum, William B	Independence	125
Mangunta, Vijaya K	New Madrid	202
Manion, Thos S	Independence	125
Manire, John E	Joplin	102
Mann, James K	Hannibal	150
Mannis, Charles I	St Louis	190
Manske, Paul R	St. Louis	190
Mantell, Jack M	Springfield	082
Mantovani, John F	St. Louis	190
Manuel, Louis C	Kansas City	125
Maple, Francis M	Springfield	082
Maranan, Diosdado L	Arnold	106
Maravilla, Levy M	St Louis	190
Marbarger, John P, Jr.	St. Louis	190
Marchiando, Albert W	Washington	074
Marchosky, J. Alex	Chesterfield	190
Marcus, Michael D	St. Louis	190
Marcus, Morris D	St. Louis	190
Mardini, Edward E	Bonne Terre	138
Mardjetko, Steven M	St. Louis	190
Margolis, David M	St. Louis	190
Margolis, Robert P	St. Louis	190
Markway, Gregory A	Independence	125
Marr, Garrett L	Kansas City	125
Marrs, David B	St. Charles	189
Marsh, Alice	Pleasant Hill	125
Marsh, Jeffrey L	St Louis	190
Marshall, Hal E	Kansas City	125
Marshall, Jay P, II	Chesterfield	190
Marshall, Nyron T	Kansas City	215
Marshall, William G	Glasgow	026
Marshall, William H	Jefferson City	058
Marston, F. James	St Joseph	030
Marti, Larry B	Rolla	135
Martin, Chris J	Columbia	026
Martin, Clarence A	Joplin	102

---

*Doctor of osteopathy.

Martin, Daniel J	St. Louis	190
Martin, David S	Chesterfield	190
Martin, J. William	Washington	074
Martin, Jeffrey W	Bridgeton	190
Martin, John N	St. Joseph	030
Martin, Mark W	Lee's Summit	125
Martin, Richard A	Cape Girardeau	042
Martin, Robert A	West Plains	206
Martin, Scott A	Chesterfield	190
Marty, David R	Jefferson City	058
Martz, John C	St. Louis	190
Maslan, Mark J	Kansas City	125
Mass, Joan H	Florissant	190
Massey, Vickie	Kansas City	125
Masters, Edwin J	Cape Girardeau	042
Masters, Wm H	St Louis	190
Mathew, Ruby	Chesterfield	190
Matile, Gerald U	Kansas City	125
Matovich, Violet B	Kansas City	125
Matson, Jeffrey A	Kansas City	125
Matta, Camille S	Kansas City	125
Mattax, James B, Jr.	Springfield	082
Matthews, J. Mark	Kansas City	125
Matthews, John I	Jefferson City	058
Matthews, John G	St. Louis	190
Matthews, Richard H	Rolla	135
Matthews, Thomas D	Washington	074
Maughs, Sydney B	St Louis	190
Mauldin, Charles C	Springfield	082
Maupin, Kathy C	Florissant	190
Maves, Michael D	St. Louis	190
Maxson, Katherine A	Chesterfield	190
Maxson, Theodore R	Warrensburg	110
May, Albert L	Poplar Bluff	034
Mayer, John H, Jr.	Kansas City	125
Mayer, Robt A	St Louis	190
Mayes, Ben R	St. Louis	190
Maylack, Fallon H	Florissant	190
Maynard, Colleen M	Kansas City	125
Mayuga, Edgardo G	St. Louis	190
Mayuga, Laureano G	Cabool	206
Mayus, Joseph L	Springfield	082
McAdam, C. Rush	St. Louis	190
McAfee, Gordon	Springfield	082
McAlhany, Howard J	Springfield	082
McBride, Lawrence R	St. Louis	190
McCabe, Eugene J	St. Charles	189
McCadden, Michael E	St. Louis	190
McCaffree, Mary K	Jefferson City	058
McCalla, John P	Kansas City	050
McCallister, Ben D	Kansas City	125
McCanse, Andrew	No. Kansas City	125
McCanse, Lynn R	No. Kansas City	050
McCarthy, Christopher	St. Louis	190
McClennan, Bruce L	St. Louis	190
McCluggage, Newton C	No. Kansas City	050
McConahay, David R	Kansas City	125
McConchie, James E	Lee's Summit	125
McCool, James F	St. Louis	190
McCorcle, Marcus D	Springfield	082
McCord, E. Scott	Columbia	026
McCormack, Robert E	Kansas City	125
McCormick, James E	Kansas City	050
McCown, Allan H	St. Louis	190
McCoy, Frederick J	Kansas City	125
McCray, Glen M	Springfield	082
McCray, Stephen A	N. Kansas City	050
McCrory, James H	Springfield	082
McCroskey, Brian L	Kansas City	125
McCroskey, Lon C	Kansas City	125
McCullough, Joseph E	Kansas City	125
McCullough, Timothy L	Chesterfield	215
McDaniel, John R	St. Joseph	030
McDavid, Robert E	Columbia	026
McDermott, Alfred E	Perryville	174
McDermott, Timothy J	Cape Girardeau	042
McDonald, Herbert L	Bolivar	125
McDonald, Margaret E	Joplin	102
McDonald, Michael G	Joplin	102
McDonald, Wallace	St. Joseph	030
McDonald, Wilbur P	St. Joseph	030
McDonnell, John F	Kansas City	125
McDowell, James W	Blue Springs	215
McElroy, Glenn L	Columbia	026
McFadden, Gene A	Waverly	118
McFarland, H. R.	Kansas City	125
McFarland, Rodney J	Neosho	166
McGinnis, Wm F	Chesterfield	190
McGinty, Chas P	Cape Girardeau	042
McGinty, Frank H	Cape Girardeau	042
McGonigle, James P	Joplin	102
McGonigle, Michael M	Joplin	102
McGovney, Janice K	Smithville	050
*__McGraw, James P__	Kansas City	215
McGuire, Patricia A	St. Louis	190
McGuire, Thomas H	Shawnee Mission	125
McIntire, Timothy L	Jefferson City	058
McIntosh, Donald E	Kansas City	125
McIntosh, Douglas A	Cape Girardeau	042
McIntosh, Michele C	Independence	125
McIntyre, John D	Kansas City	125
McKeel, Thos B	Kansas City	125
McKinley, Lois J	Kansas City	125
McKinney, Daniel C	Springfield	082
McKinney, John W	St. Louis	190
McKinney, William D, Jr.	Belleview	138
McKinsey, David S	Kansas City	125
McKnelly, Wm V, Jr.	Kansas City	125
McKnight, Scott J	Liberty	050
McLaren, David L	Columbia	026
*__McLaughlin, Dan A__	St. Joseph	030
McLaughlin, Durnell	Kansas City	125
McLaughlin, Richard D	Springfield	082
McLear, Patrick W	St. Louis	215
McLemore, Willie O	Kansas City	125
McMeekin, Sheila P	Overland Park	125
McMillan, David L	Neosho	166
McMillen, James J	St. Joseph	030
McMillin, John N	Springfield	082
McMullin, Forbes A	St Louis	190
McMurray, Scott W	Springfield	082
McNamara, John J	St. Louis	190
McNeal, Douglas M	Springfield	082
McNitt, Jay D	Kansas City	125
McPhee, Mark S	Kansas City	125
McPhee, Wm R	Kansas City	050
McQueary, Frederick G	Springfield	082
McQuillan, Robert J	Kansas City	215
McVey, Pamela S	Kansas City	125
Meacham, Joseph A	St. Louis	190
Meadows, C. Douglas	St Louis	190
Mechlin, David C	Columbia	026
Medler, John F	St Louis	190
Medler, P. Louis	St Louis	190
Medlicott, William J	Port Townsend	125
Meegan, Robt J	Overland Park	125
*__Meghjee, Zinnat__	Olney	215
Mehaffy, Orville A	Joplin	102
Mehan, Donald J	St Louis	190
Mehlhorn, Gary L	Springfield	082
Mehra, Ravi	St. Louis	190
Meier, Francis X	Jefferson City	058
Meinberg, William H	North Ridge	190
Meiners, David J	St. Louis	190
Meiners, Theodore M	Chesterfield	190
Meldi, Dominic M	Springfield	082
Melgaard, Sven R	Leawood	125
Melia, B J, Jr.	Kansas City	125
Mell, Roger L	Chesterfield	190
*__Mellies, Steven D__	Cape Girardeau	042
Melson, G. Leland	St Louis	190
Meltz, Gary J	St. Charles	189
Memken, John A	Hannibal	150
Menchetti, Donald E	Springfield	082
Mendelsohn, George E	Chesterfield	190
Mendelsohn, Robert S	St. Louis	190
Mendez, Maria A	Springfield	082
Mendonsa, Lawrence E	Chesterfield	190
Menne, Marvin C	Ironton	138
Mentel, John J	St. Peters	189

---

*Doctor of osteopathy.

Mentgen, Carl N	082	Springfield
Meredith, William R	102	Joplin
Merenda, Frank J	190	St. Louis
Merenda, James T	190	St. Louis
Merenda, Sam J	190	St Louis
Merkel, Kurt D	190	St. Louis
Merkle, John A	190	St. Louis
Merritt, Burch A	190	St. Louis
Mertz, Janet S	125	Kansas City
Merys, Shawn C	215	Kansas City
Mestad, Peter H	125	Kansas City
Mestres, Hugh M	190	St Louis
Metry, Donald J, Jr.	078	Chillicothe
Metzl, Kurt	125	Kansas City
Metzler, Michael H	026	Columbia
Meyer, Bruce A	002	Kansas City
Meyer, Harry E	190	St. Louis
Meyer, Jay	190	St. Louis
Meyer, Jerry L	118	Concordia
Meyer, John W	082	Springfield
Meyer, John S	190	Chesterfield
Meyer, Joseph V	215	Clayton
Meyer, Melvin E	190	St Louis
Meyer, Paul W	125	Shawnee Mission
Meyer, Randall E	058	Jefferson City
Meyer, Robert C	190	St. Louis
Meyer, Wayne W	190	Bridgeton
Meyerrose, Gary E	215	Ballwin
Meyers, Elsie F	190	St. Louis
Meyers, Jerry R	189	St. Peters
Meyers, John B	190	St. Louis
Meyers, Robert W	190	St. Louis
Meystrik, Rosellen S	082	Springfield
*Michael, Roy A	058	Jefferson City
Michael, Vernon E	190	St Louis
Michaelree, John F	190	Ballwin
Michaels, Robert H	082	Springfield
Michelson, Richard B	125	Kansas City
Middleton, Jerry N	190	Chesterfield
Middleton, Mary A	190	St. Louis
Miedema, Brent W	026	Columbia
Mihalevich, John A, Jr	082	Springfield
Milder, Barry D	190	St. Louis
Milder, Benj	190	St. Louis
Miles, Geo O	125	Shawnee Mission
Miles, Paul W	190	Chesterfield
Miles, Wayne B	082	Springfield
Milgram, Byron A	125	Kansas City
Mill, Wm B, Jr.	190	St. Louis
Miller, Burney A	118	Blue Springs
Miller, Charles W	190	St. Louis
Miller, Chas , Jr.	190	St. Louis
Miller, Dace L	082	Springfield
Miller, Donald	058	Jefferson City
Miller, Gayle P	125	Kansas City
Miller, Geoffrey W	190	St. Louis
Miller, Gerald L, Jr.	125	Kansas City
Miller, Harry G	086	Clinton
Miller, James E	190	St. Louis
Miller, John T	125	Kansas City
Miller, Joseph P	042	Jackson
Miller, Jule P	190	St Louis
Miller, Leroy J	026	Columbia
Miller, Michael R	125	Kansas City
Miller, Pamela S	215	Columbia
Miller, Robert N	190	St. Louis
*Miller, Robin C	190	Ballwin
Miller, William D	030	St. Joseph
Miller, William D	202	Dexter
Miller, Wilson H	125	Kansas City
Miller, Exec. Dir., Judy	001	Joplin
Millet, Ruth E	125	Kansas City
Mills, Melissa J	002	Kansas City
Milne, Jay L	082	Springfield
Milsten, Marc S	215	Shawnee Mission
Milster, Clyde R	190	St Louis
Miltenberger, Paul C	070	Columbia
Mink, Jonathan W	215	St. Louis
Minke, Thomas A	215	Creve Coeur
Minkoff, I. Monica	189	St Peters
Minnigerode, Lana K	125	Kansas City
Minnigerode, Turner L	125	Kansas City
Mir, A. Rauf	125	Kansas City
Mirbaha, Mitchell M	190	St. Louis
Mire, Louis E	082	Springfield
Mirowitz, Scott A	190	Creve Coeur
Mischnick, Carol R	190	Chesterfield
Mishkin, Marvin R	190	St Louis
Miskovsky, Emil F	190	Bridgeton
Missey, Wilburn C	190	Chesterfield
Mistry, Tehmton S	190	Chesterfield
Mitchell, Andrew D	125	Prairie Village
Mitchell, Edith P	026	Columbia
Mitchell, Franklin L	026	Columbia
Mitchell, John D	125	Kansas City
Mitchell, Lynn D	026	Columbia
Mitchell, Robt H	125	Kansas City
Mitchell, Thos J	074	St. Clair
Mitchem, Olevia	125	Kansas City
*Mitchem, Randall E	215	Shawnee Mission
Mitra, Nirmal K	125	Kansas City
Mittleman, Frederick S	125	Prairie Village
Mizell, Myron W	082	Springfield
Mobley, Gilbert L	082	Springfield
Moeller, F. Delbert	189	Lake St. Louis
Moeller, Randall J	030	St. Joseph
Moffe, Thomas C	082	Springfield
Mohrman, Raymond F	190	Bridgeton
Mohs, Frank R	190	St. Louis
Mohsen, Aly M	082	Springfield
Molberg, Peter J	082	Springfield
Molden, C. Scott	190	St Louis
Molden, Chas A	190	Bridgeton
Mollman, H. Dennis	190	Chesterfield
Monaco, Michael	125	Kansas City
Monafo, William W	190	St. Louis
Monaghan, Greg G	026	Columbia
Mongan, James J	125	Kansas City
Monroe, C. Dean	026	Columbia
Monson, Bruce	215	Mission
Monteleone, Patricia L	190	St. Louis
Montello, Samuel A	125	Shawnee Mission
Monterubio, Fred R, Jr.	190	St. Louis
Montes, Arturo C	190	Florissant
Montes De Oca, Julio	190	St. Louis
Montgomery, Austin F	190	St. Louis
Montgomery, John H, III	102	Joplin
Montgomery, Michael A	125	Kansas City
Montgomery, Scott A	215	Kansas City
Moolsintong, Pornchai	190	St. Louis
Mooney-Smith, Patricia	125	Kansas City
Moore, Candice A	214	Topeka
Moore, David L	125	Kansas City
Moore, De Armond	082	Springfield
Moore, Harry G, Jr.	190	St. Louis
Moore, Jack D	125	Kansas City
Moore, John M	125	Kansas City
Moore, Michael R	206	West Plains
Moore, Michael T	214	Nevada
Moore, Richard E	042	Cape Girardeau
Moore, Thomas B	102	Joplin
Moore, Walter L	190	St. Charles
Moore, Exec. Sec., Patty	001	St. Joseph
Mora, Alvaro	190	Bridgeton
Moran, Christopher J	190	St. Louis
Moran, Thos M	190	St Louis
Morantz, Robert A	125	Kansas City
Moranville, Benedict A	030	St. Joseph
Moranz, John W	034	Van Buren
Morehead, Wm E	070	Malden
Morehouse, Paul D	074	Washington
Moreton, David W	215	Columbia
Morey, Kirk P	190	St. Louis
Morgan, Charles H	082	Springfield
Morgan, David B	125	Kansas City
Morgan, Dix R	042	Cape Girardeau
Morgan, Harry C	190	Waynesville
Morgan, John L	082	Springfield
Morgan, Richard L	125	Kansas City
Morgan, Stephan S	190	St. Louis

---

*Doctor of osteopathy.

Morgan, W. Tom , Jr.	Columbia	026
Morgan, Willy J C	East St. Louis	190
Moriconi, William J	St. Louis	190
Moritz, Gerald	Bridgeton	190
Moritz, K. Lynne	St. Louis	190
Morley, Mary A	Chesterfield	190
*Morley, Ronald F	Jefferson City	058
Morris, Alan H	St Louis	190
Morris, Barbara A	Kansas City	125
Morris, J H	Independence	125
Morris, John J	Columbia	026
Morris, R. William	St. Louis	190
Morris, Terry V	Independence	125
Morrison, Arlen E	Chesterfield	190
Morrison, Carrie C	Columbia	215
Morrison, R. Gideon	Sedalia	178
Morrison, Richard A	Shawnee Mission	125
Morrison, Robert R	Kansas City	125
Morrison, Stephen K	Springfield	082
Morrison, Thos A	Aurora	166
Morrison, Tom V	Branson	208
Morrow, N. Eugene	Springfield	082
Morse, John P	Kennett	070
Mortensen, Frede	St. Louis	190
Morton, David J	St. Louis	190
Morton, Paul C	Springfield	082
Morton, Wayne L	Osceola	214
Mosbacher, Hugh E	Lee's Summit	125
Mosby, Larry D	Columbia	026
Moseley, Brad	Silver City	120
Moseley, F. Thomas	Springfield	082
Moses, Robert A	St. Louis	190
Mosley, Julian C	St Louis	190
Moss, Paul	Shawnee Mission	125
Mossie, Raymond D	Gladstone	050
Motchan, Dennis G	Bridgeton	190
Mothershead, John L	St. Joseph	030
Motier, Thomas H	St. Louis	190
Mou, Susan M	Kansas City	125
Moulton, Michael J	St. Louis	215
Mowrey, Wm O	St Louis	190
Moya, Carlos E	St. Joseph	030
Mrosak, Daniel R	Lexington	118
Muckerman, Richard C, II	St. Louis	190
Muckerman, Richard I	St. Louis	190
Muegge, F. David	Springfield	082
Muehlebach, Gregory F	Kansas City	215
Muehlebach, Victoria	Kansas City	215
Muelleman, Peter J	Independence	125
Mueller, Adolph R	Joplin	102
Mueller, Clarence E	O'Fallon	190
Mueller, Howard A	Bloomington	190
Mueller, John J	St. Louis	190
Mueller, Jos A	St Louis	190
Mueller, Martin J	Kansas City	125
Mueller, Morris A	San Antonio	190
Mueller, Randall E	Columbia	026
Muhammud, Faquir	St Louis	190
Muhm, Harvard Y	St Charles	189
Mujica, Patricio H	St. Joseph	030
Mukharji, Jhulan	Kansas City	125
Mulder, George D	St. Joseph	030
Mullarky, Wilbur A	Oviedo	190
Mullen, Jack	Bonne Terre	138
Mullen, Mary E	Mexico	014
Mullins, Bernard L	Kansas City	050
Mullins, John E	Chesterfield	190
Mundy, William L	Merriam	125
Munger, Michael L	Kansas City	125
Munro, John S	Kansas City	125
Muraywid, Ahmad H	Mexico	014
Murdock, Nathaniel	St. Louis	190
Murphy, Brian P	Raytown	125
Murphy, Daniel J	Bridgeton	190
Murphy, J. Peter , Jr.	St. Louis	190
Murphy, James A	St Joseph	030
Murphy, John P	Overland Park	125
Murphy, Timothy P	St. Joseph	030
Murphy, Wm A, Jr.	St Louis	190
Murray, Eric	Jefferson City	058
Murrell, H. Jerry	Columbia	026
Muscato, Joseph J	Columbia	026
Muscato, Mary S	Columbia	026
Muschany, Norman K	St. Louis	190
Mutchnick, Norman	Kansas City	125
Muzaffaruddin, Mohammed	St. Louis	189
Myears, Donald W	Springfield	082
Myers, Carl M	Platte City	125
Myers, Duane E	Joplin	102
Myers, Geo H	Kansas City	125
Myers, Ivan T	St. Louis	190
Myers, James M	Rolla	135
Myers, John S	Kansas City	125
Myron, Mark C	Kansas City	125

N

Nachtigal, Michael P	Springfield	082
Nagy, Al L	Poplar Bluff	034
Nagy, Rickey E	Kansas City	125
Naime, Mansour J	Kansas City	125
Nakra, Bharat Raj	St. Louis	190
Nakra, Rashmi R	St. Louis	190
Nanson, Duane	Columbia	026
Narayan, Dilip L	Chesterfield	190
Narkiewicz, Lawrence S	St Louis	190
Naseer, Riaz A	St. Louis	190
Nash, Helen E	St Louis	190
Nash, Homer E, Jr.	St. Louis	190
Nashelsky, Marcus B	Columbia	215
Nathan, Lester J	St. Louis	190
Naunheim, Keith S	St. Louis	190
Navato, Jose R	Independence	125
Navato-Dehning, Cielo D	Independence	125
Nayar, Gopal K	Chesterfield	190
Neal, James G	Springfield	082
Near, David M	Florissant	190
Neblett, Lewis M	Rogersville	082
Neblock, Tammy	Kansas City	215
Neighbor, Ernest H	Kansas City	125
Neihart, Robert E	Kansas City	125
Nelson, Bentley A	Leawood	125
Nelson, David E	Springfield	082
Nelson, Donald C	Springfield	082
Nelson, J. Roger	St Louis	190
Nelson, Paul W	Kansas City	125
Nelson, Richard E	Kansas City	125
Nemec, Edward S	St. Louis	190
Nepute, James A	St. Louis	190
Nesselrode, John H	Independence	125
Neu, Leo T, Jr	Springfield	082
Neu, Leo T, III	Springfield	082
Neuman, Neal	St. Louis	190
Newbold, Steven E	Kansas City	125
Newman, Mary J	Cassville	166
Newman, Matthew	St. Louis	190
Newman, Robert L	Kansas City	125
Newman, William R	Joplin	102
Newman-Koehn, Mica K	Marshall	198
Newport, Gerald	Florissant	190
Nguyen, Helen T	St. Joseph	030
Nicholas, Stephen P	St. Louis	190
Nicholis, G. Ronald	Kansas City	125
Nichols, W. Kirt	Columbia	026
Nickell, Margaret B	Kansas City	125
Nickell, Michael D	Joplin	102
Nicolai, Chas H	St. Louis	190
Niedermeyer, George J	St. Louis	190
Nielsen, Carl H	St. Louis	190
Nierling, Dean A	Columbia	026
Niesen, Anna R	St. Louis	190
Niesen, Frank J	St Louis	190
Niesen, Thomas E	Chesterfield	190
Nieuwenhuizen, Maarten	Columbia	026
Nigh, Chas A	St. Louis	190
Nigro, Thomas L	Kansas City	125
Nishi, Toshio	St. Louis	190
Nitzel, Scott A	Kansas City	215
Nix, J. Gustavo	Bolivar	066

---

*Doctor of osteopathy.

Nixon, Edward E	Gallatin	078
Noback, Richardson K	Kansas City	125
Nolan, Chas J	Chesterfield	190
Nolph, Georgia J	Columbia	026
Nolph, Karl D	Columbia	026
Noltensmeyer, Milton H	Shawnee Mission	125
Nomura, Roy M	St Louis	190
Noor, Sidi Y	St. Geneieve	174
Nordlicht, Scott M	St. Louis	190
Norland, Chas C	St Louis	190
Nouhan, Joseph G, Jr.	St. Louis	190
Nourbakhsh, Mahmoud M	Kansas City	050
Nouri, Hassan	St Louis	190
Novack, Mark A	Chesterfield	190
Nowotny, Thomas J	St. Louis	190
Nuetzel, John A	St. Louis	190
Nulton, Carnie C	Kansas City	125
Nussbaum, Larry	Liberty	050
Nwaobasi, Sam	Florissant	190
Nyazee, Muhammad A	Bridgeton	190

O

O'Brien, Edward J, Jr.	St Louis	190
O'Brien, Robert M	St. Louis	190
O'Brien-Su, Eileen M	Prairie Village	215
O'Connell, Timothy	St. Louis	190
O'Connor, Edward F	Versailles	120
O'Connor, John J	St. Louis	074
O'Connor, Robert J	Florissant	190
O'Donnell, Francis E	St. Louis	190
O'Dowd, Mary K	Chesterfield	002
O'Farrell, Thos P	Kansas City	125
O'Hearne, John J	Kansas City	125
O'Keefe, James H, Jr.	Kansas City	125
O'Keefe, Timothy	Joplin	102
O'Kell, Richard T	Kansas City	125
O'Malley, James F	Leawood	125
O'Meara, Clifton B	Sedalia	178
O'Neal, Lawrence W	St. Louis	190
O'Neal, Patricia L	St Louis	190
O'Neil, James H	Port Charlotte	125
O'Neil, Jerome H, Jr.	St. Louis	190
O'Reilly, D. Elliott	St. Louis	190
O'Sullivan, Danl F	St Louis	190
O'Toole, Lisa	Overland Park	215
O'Toole, Patrick M	Kansas City	125
Oakley, Margaret M	St Louis	190
Occeno, Victor G	Cassville	166
Ockner, Samuel A	St. Louis	190
Oehler, William F	Cape Girardeau	042
Ohlms, David L	St Louis	190
Ojascastro, Alejandro C	St. Louis	190
Ojile, Joseph M	St. Louis	190
Oleson, Gale B	Blue Springs	125
Olive, G. Chapman	Springfield	082
Olive, Geo C	Neosho	166
Olive, Paul M	Springfield	082
Oliver, G. Charles	St. Louis	002
Oliver, George A	Farmington	138
Olk, R. Joseph	St. Louis	190
Olsen, Teresa A	Springfield	082
Olson, E. Rule	Springfield	082
Olson, James H	Liberty	050
Olson, Lloyd C	Kansas City	125
Olson, Richard O	St Charles	189
Olson, Robert J	Springfield	082
Olson, Stephen A	Mission	215
Omell, Gary H	St. Louis	190
Onder, Robert F	St. Louis	190
Ong, Eng L	St. Louis	190
Ong, Ofelia S	St. Louis	190
Onken, Henry D	St Louis	190
Oppenheimer, Henry E	St. Louis	190
Opper, Susan E	Kansas City	125
Oppermann, Karen J	Kansas City	125
Orgel, S. Michael	St Louis	190
Orlando, Louis A	Kansas City	125
Oro, John J	Columbia	026
Orsay, Paul K	St. Louis	190
Ortbals, David W	Chesterfield	190
Ortega, Steven A	Joplin	102
Orth, O. Gerald	Columbia	026
Ortiguero, Leopoldo M	St Louis	190
Ortmeyer, Leroy F	St. Louis	190
Osbourn, Richard A	Fulton	038
Osgood, Brian M	Independence	125
Ossman, Julian A	Jefferson City	058
Ost, Mark D	Kansas City	125
Ostapowicz, Frank	St. Louis	190
Ostapowicz, Tamara L	St. Louis	190
Ostergaard, Daniel J	Kansas City	125
Ostrow, Bridget F	Cape Girardeau	042
Ostrow, Louis B	Cape Girardeau	042
Othmer, Ekkehard	Kansas City	050
Ott, F. Thomas	St. Louis	190
Ott, Harold J	St Louis	190
Ott, William J	St. Louis	190
Otten, Joseph V	Bridgeton	190
Ottinger, Christopher M	Kansas City	215
Otto, William J	Springfield	082
Ouellette, David F	Hannibal	150
Ovens, Lisa	Springfield	082
Overend, Don S	Springfield	082
Overesch, Harry B	Kansas City	125
Owen, Robt F	St Louis	190
Owens, Robt H	Kansas City	125
Owens, William D	St Louis	190
Ozar, Milton B	Kansas City	125
Ozenberger, Larry A	Plattsburg	054
Ozmat, Orhan M	St Louis	190

P

Pacheco, Jose M	Springfield	082
Packman, Paul	St Louis	190
Packman, Robt C	St. Louis	190
Padilla, Pedro C	Troy	189
Padilla, Teresita C	Chesterfield	190
Padula, Richard T	Kansas City	125
Paez, Mauro A	St. Louis	190
Page, Sam L, Jr.	St. Louis	215
Paine, Robert	Chesterfield	190
Painter, Andrew E	Portageville	202
Painter, Lattie B	Portageville	170
Pal, Michelle L	Kansas City	125
Palazola, Joseph M	Kansas City	125
Palcheff, Chris L	Springfield	082
Palen, James E	Cape Girardeau	042
Palenske, Robt L	Hornersville	070
Paletta, Christian E	St. Louis	190
Paletta, Francis X, Sr.	St. Louis	190
Paletta, Frank	St. Louis	190
Paletta, Theodore L	St. Louis	190
Paletta, Victor L	Bridgeton	190
*Palmer, Allen S	Bridgeton	190
Palmer, Russell H	Palmyra	150
Palmer, Stephen M	St. Louis	190
Palmer, Ex. Dir., John	Kansas City	001
Pancoast, Charles H	Cape Girardeau	042
Panek, Judy L	Kansas City	125
Paone, Douglas B	Kansas City	125
Pappalardo, Carlos	St Louis	190
Papreck, K T	Marshall	198
Paradelo, Jorge C	Kansas City	125
Pardo, Leopoldo P	St. Louis	190
Pardo, Lourdes S	St. Louis	190
Parelman, Allen G	Kansas City	125
Parelman, Joseph J	Kansas City	125
Parikh, Sharad P	Florissant	190
Parikh, Smita S	Florissant	190
Paris, Wm H	Bridgeton	190
Park, Bert E	Springfield	082
Park, Tae S	St. Louis	190
Park, Wm I, Jr	Springfield	082
Parker, Arthur C	Destin	034
Parker, Brent M	Columbia	026
Parker, Craig A	Kansas City	125
Parker, Joseph C, Jr	Louisville	125
Parker, Kim E	Kansas City	125

---

*Doctor of osteopathy.

Parker, Thos W	St Louis	190
Parker, Wm	St. Louis	190
Parkins, George K	Kansas City	125
Parks, Charles	St. Louis	190
Parks, Deborah L	St. Louis	190
Parks, William C	Columbia	026
Parra, Raul O	St. Louis	190
Parsons, Clyde W, III	Springfield	082
Parsons, Richard P	Marthasville	190
Partamian, Krikor O	St. Joseph	030
Partap, Prabha	St Louis	190
Parulekar, Dilip G	Fulton	038
Parwatikar, Sadashiv D	St Louis	190
Paskar, Larry D	Chesterfield	190
Paskon, Seth	Salem	135
Passanante, Bartholomew M	St Louis	190
Patel, Ashokkumar B	St. Louis	190
Patel, Bipin T	St. Joseph	030
Patel, Indu B	Barnhart	106
Patel, Natu B	Bethany	078
Patel, Prakesh B	St. Joseph	030
Patel, Raman J	St. Joseph	030
Patrick, Roman L	St. Louis	190
Patterson, Donald C	Columbia	026
Patterson, Donald R	Joplin	102
Patterson, Grover S	Carthage	102
Pattison, Charles P	Kansas City	125
Patty, Carl F	Poplar Bluff	034
Patty, John R	Poplar Bluff	034
Pauls, Scott W	Kansas City	215
Paulson, Gordon S	St. Joseph	030
Pavelonis, Joel D	Kansas City	002
Pavlovich, Andrew S	Independence	125
Pavlu, Robert R	Waverly	118
Pawsat, John E	Kansas City	125
Payne, David E	Columbia	026
Payne, John W	Fulton	026
Payne, Meredith C	Chesterfield	190
Pearce, Eugene W	Kansas City	125
Pearlman, Alan L	St Louis	190
Pearse, Carlton S	Chesterfield	190
Pearse, Roy W	Forsyth	214
Pearson, Thomas C	Springfield	082
Pearson, William E	St. Louis	190
Peck, William A	St. Louis	190
Peden, Burnet W	St. Louis	190
Peden, Virginia H	St. Louis	190
Peeples, David M	Ballwin	190
Peete, Don C	Prairie Village	125
Pehlman, Jos E	Malden	070
Peick, Ann C	Poplar Bluff	034
Peigh, Pamela S	St. Louis	190
Pelican, George	St. Louis	190
Pendell, Paul W	Raymore	125
Pendergrass, Kelly B	Kansas City	125
Penilla, Antonio R	Bridgeton	190
Penkoske, Michaele M	St. Charles	189
Pennell, Richard C	St. Louis	190
Penney, Larry L	Columbia	026
Penninger, William H	Springfield	082
Pennington, D. Glenn	St. Louis	190
Pennington, Michael S	Springfield	166
Pennoyer, James	St. Louis	190
Peplinski, Gary R	St. Louis	215
Pepose, Jay S	St. Louis	002
Pepper, Edward G	St Louis	190
Pereira, MaryBeth	St. Louis	190
Perez, Adamor R	St Louis	190
Perez, Blanca M	St. Louis	190
Perez, Carlos A	St Louis	190
Perez, Jeannie O	Bridgeton	190
Perez, Raul E	St. Louis	190
Perez, Robert J	St. Louis	190
Perkins, David E	Chesterfield	190
Perll, Maurice F, Jr.	Kansas City	125
Perll, Michael F	Kansas City	125
Perll, Rita D	Kansas City	125
Perlmutter, John C	St. Charles	189
Perlstein, Laurence F	Florissant	190
Perna, Vincent P	St. Louis	189
Pernoud, Flavius G, III	St. Louis	190
Pernoud, Flavius G, Jr.	St. Louis	190
Pernoud, Joan M	St. Louis	190
Pernoud, Michael F	St. Louis	190
Perry, Michael C	Columbia	026
Perryman, John C	Kansas City	125
Perryman, Kathy M	Kansas City	125
Peters, Walter R	Columbia	026
Petersen, Larry D	Springfield	082
Peterson, Carl M	Kansas City	125
Peterson, Craig A	Springfield	082
Peterson, Frederick D	St Louis	190
Peterson, Jay T	Kansas City	125
Peterson, John E	Kansas City	125
Peterson, Stanley S	Springfield	082
Peterson, Walter R	Kansas City	125
Petit, Carl A	Osage Beach	120
Petkovich, Frank O	St. Louis	190
Petrie, Roy H	St. Louis	190
Petros, John A	University City	215
Petros, Teresa M	University City	215
Petruska, Paul J	St Louis	190
Pew, Becky A	St. Louis	190
*Pewitt, Charles S	Jackson	042
*Pfautsch, Mark L	Cape Girardeau	042
Pfefer, Leland U	Columbia	026
Pfeffer-Hurwitz, Judith	Overland Park	125
Pfefferkorn, David A	Sikeston	202
Phanijphand, Suwan	Poplar Bluff	034
Phelan, Christie B	Shawnee Mission	215
Philgreen, Donald E	Kansas City	125
Phillips, Abraham M	St. Louis	190
Phillips, Daniel	St. Louis	190
Phillips, John G	St. Louis	215
Phillips, John J	Florissant	190
Phillips, Ronald L	Kirksville	148
Phillips, Stephen W	Columbia	026
Phillips, Thomas P	Kansas City	125
Phillips, Wm J	Chesterfield	190
Philpott, Gordon W	St Louis	190
Pickard, Clarence M	Columbia	026
Pickard, Nicholas S	Shawnee Mission	125
Pickens, Andrew T	St. Louis	190
Picker, Selwyn	St. Louis	190
Pickering, Lee I	Independence	125
Picus, Joel	St. Louis	002
Piebenga, Larry W	Kansas City	125
Piehler, Jeffrey M	Kansas City	125
Pifer, Lawrence H	St. Joseph	030
Pignotti, Blase J	St. Louis	190
Piker, K. Dewayne	Springfield	082
Pimentel, Esperanza M	St Louis	190
Pinckley, James N	Springfield	082
Pineda, Hector O	St Louis	190
Pineda, Juan J	Columbia	215
Pingelton, William B	Columbia	026
Pingleton, William W	Shawnee Mission	050
Pinkerton, Joe A, Jr.	Kansas City	125
Pinkham, Chris M	Kansas City	050
Piontek, James F	Liberty	050
Piontek, Jerome G	Chesterfield	190
Piper, August T	St. Louis	190
Piper, Donald K	Leawood	125
Piquette, Craig A	St. Louis	215
Pitiyanuvath, Tasanaporn	Kansas City	125
Pitney, Phillip W	Louisiana	186
Pitsinger, N. Bruce	Chesterfield	190
Pittman, Christopher	St. Louis	215
Pittman, David L	Columbia	026
Pittman, Gerald R	St. Louis	190
Pittman, Susan	St Louis	190
Pittmann, Thomas	St. Louis	190
Place, Kenneth C	Kansas City	125
Plax, Steven I	St Louis	190
Plowman, Edward M	Hannibal	150
Podrecca, Guido I	Springfield	082
Poger, Marshall E	St. Louis	190
Poggemeier, Wm H	St. Charles	189
Pogson, George W, III	Independence	125
Pohl, David L	St. Louis	190

---

*Doctor of osteopathy.

Pohl, Ronald L Mission	215
Pojanasomboon, Pichat Rolla	135
Politi, Gregory B Kansas City	125
Politte, Lenard L Columbia	026
Pomphrey, Martin M, Jr. St. Louis	190
Pompushko, Rosalie Kansas City	125
Pon, Marcelino St. Louis	190
Pontillas, Job B Perryville	174
Poole, Anthony G Sikeston	202
Poonawala, Huseni E Kansas City	125
Popp, Dennis A St. Louis	190
Porter, Charles B Kansas City	125
Porter, Michael J Kansas City	125
Porter, Susan S Kansas City	125
Porter, Walter N, Jr. Lenexa	125
Portnoff, Lee S St. Louis	190
Portnoy, Jay M Kansas City	002
Porubsky, Gary L No. Kansas City	050
Posey, Douglas H, Jr. St. Joseph	030
Post, Stephen L St Louis	190
Postma, George S, Jr. Shawnee Mission	125
Potashnick, Robert St. Louis	190
Pottenger, L. Kenneth Joplin	102
Potter, Caryl A, Jr St. Joseph	030
Potter, Reese H St. Louis	190
Potts, Dan E Chesterfield	190
Potts, Donald A Kansas City	125
Potts, Fred E, III Springfield	082
Potts, Gregory A Washington	074
Powell, Alan E Independence	125
Powell, Cynthia K Farmington	138
Powell, Edwin M Springfield	082
Powell, John A St Louis	190
Powell, Kenneth R Springfield	082
Powell, Lisa G Springfield	082
Powers, Catherine A Leawood	125
Prater, Bill G Springfield	082
Prater, Kimberley A Springfield	082
Prater, Thomas G Springfield	082
Prelutsky, David J St. Louis	190
Prensky, Arthur L St Louis	190
Presley, Jimmy C Springfield	082
Preston, Bruce E West Plains	206
Previti, Vincent Springfield	082
Prewitt, David W St. Louis	215
Prewitt, Maryann E St. Louis	215
Prey, Marianne U St. Louis	190
Prica, George , Jr Columbia	026
Price, Hilton I St. Louis	190
Price, Patrick K Fairway	125
Price, Richard C Harrisonville	214
Price, Richard B Kansas City	125
Prickett, David C, Jr Kearney	050
Pringle, Scot G Cape Girardeau	042
Pro, John D Kansas City	125
Probst, James R St. Louis	190
Probst, Raymond E St Louis	190
Probstein, Jacob G St. Louis	190
Prochaska, Mark L Overland Park	125
Proctor, Donald C Sedalia	178
Prokop, Joseph R St. Joseph	030
Prophete, Yves R St. Louis	190
Proskey, Vincent J Chesterfield	190
Prostic, Edward J Kansas City	125
Prstojevich, Steven J St. Louis	215
Pruett, Burchard S St Louis	190
Pruett, Don S St. Louis	190
Pruett, Paul L Springfield	082
Pruitt, Robert M Kansas City	215
Pryor, Harold J Kansas City	125
Pryor, Ira Joe Joplin	102
Puckett, Charles L Columbia	026
Pugh, Richard G Blue Springs	125
Purcell, Harry K St. Louis	190
Purcell, Henry E St. Louis	190
Purcell, John J, Jr. St Louis	190
Purcell, Paul W Renton	050
Purcell, Richard D Springfield	082
Puro, Edward A Florissant	190
Putnam, John L Springfield	082
Pyeatte, Jacob P, Jr. Cape Girardeau	042
*Pyron, Jimmy W Joplin	102

Q

Qazi, Nasreen St. Louis	190
Quer, Erich A Shawnee Mission	125
Quiason, Arturo G Independence	125
Quiason, Emmeline P Independence	125
Quick, Gary Chesterfield	190
Quick, Richard T St Louis	190
Quick, William W Kansas City	125
Quinlan, Vincent J Mission	215
Quinn, Paul S Strafford	082
Quinn, Rodney D Springfield	082
Qureshi, Abdul R St Louis	190

R

Raborar, Arteso C Springfield	082
Rabun, John S St. Louis	215
Rabushka, Sanford E St. Louis	190
Racela, Antonio S, Jr. Shawnee Mission	125
Rachlin, Maxwell Ellington	190
Radel, Steven M New Haven	074
Rader, Ada E Kansas City	125
Rader, Edward S St. Louis	190
Radford, Diane M St. Louis	190
*Radinsky, Stephen St. Louis	190
Ragland, John E Crownpoint	058
Rahman, Moududur St Louis	190
Raible, Michele D Kansas City	125
Raich, Robt A Kansas City	125
Raichle, Marcus E St Louis	190
Raju, Niranjana Ste. Genevieve	174
Raju, Padma I Altoona	190
Raksakulthai, Vinai Fredericktown	138
Rall, Kenneth L Independence	026
Ramey, Ehret O Kansas City	125
Ramirez, Jose A St. Louis	190
Ramirez, Raymundo E Poplar Bluff	215
Ramirez, Ricardo M Kansas City	034
Ramirez, Samuel G St Louis	190
Ramirez-Inawat, Rebecca C Chesterfield	190
Ramos, Americo G Mission Hills	125
Ramos, Richardo R St. Louis	215
Ramsey, J. Darryl Cape Girardeau	042
*Ramsey, Jesse R Cape Girardeau	042
Ramsey, Robt H Florissant	190
Randall, Exec. Sec., Deonna St. Charles	001
Randolph, Bernard C, Jr. St. Louis	002
Randolph, Bernard C St Louis	190
Randolph, Kerry A Springfield	082
Rangineni, Rajagopal St. Joseph	030
Rankin, Diane St. Louis	190
*Rankin, Wendell D Joplin	102
Rao, Aswath N St. Louis	190
Rao, Carlo Florissant	190
Rao, Sumati St. Louis	190
Rapp, Earl L Hannibal	150
Rappold, Henry O Chesterfield	190
Rardin, Mary L Kansas City	125
Rasmussen, Keith G St. Louis	002
Ratcliff, Keith M Washington	074
Ratkin, Gary A St. Louis	190
Ratnam, Dasari V Kansas City	125
Rau, Michael E Washington	074
Ravi, Latha St. Louis	002
Rawlins, Fred E Cape Girardeau	042
Rawson, Perry G Washington	074
*Ray, Curt L Mission	002
*Ray, Terry L Columbia	026
Raybould, Michael W Kansas City	125
Rayford, Walter Kansas City	215
Raynor, Richard C Marshall	198
Raza, Syed A Belleville	190
Razzaq, A. St. Louis	190
Rea, James L Jefferson City	058
Reardon, Thomas M Kansas City	050

---

*Doctor of osteopathy.

Reardon, Thos F	St. Louis	190
Rector, Joe L	Shawnee Mission	125
Reddy, Abbiah N	Poplar Bluff	034
Reddy, Agara S	Columbia	026
Reddy, Anchala N	West Plains	206
Reddy, Nalini A	West Plains	206
Reddy, R. Ramachandra	Cape Girardeau	042
Redfern, David L	Springfield	082
Redington, James C, Jr.	St Louis	190
Redmon, Conchita M	Nixa	082
Rednam, Krishnarao V	Kirkwood	190
Reed, Glen H	Appleton City	214
Reed, Wm A	Kansas City	125
Reeder, Chas C	Smithville	050
Reeder, Stephen M	Springfield	082
Reese, Jeffrey C	Chesterfield	190
Reese, Jon A	Springfield	082
Reese, Lester T	St. Louis	190
Reeves, Col., Glen I	Chevy Chase	190
Regier, Carl M	Palm City	208
Reh, Edward P, Jr.	St. Louis	190
Reh, Thos E	St Louis	190
Reichert, Timothy J	St. Louis	190
Reimer, Donald R	Cape Girardeau	042
Reinhard, Edward H	St. Louis	190
Reinhardt, John R	Kansas City	125
Reinsel, Mark S	Kansas City	002
Reintjes, Stephen L	Kansas City	125
Reisler, David M	Chesterfield	190
Reiss, Jeanne E	Kansas City	125
Reisser, John R	Cape Girardeau	042
Reister, Dorothy D	Kansas City	125
Reister, Philip D	Kansas City	125
Reisz, Colleen C	Prarie Village	215
Rejent, Anthony J	St Louis	190
Remis, Robert E	St. Joseph	030
Remo, Jose' A, Jr.	Sullivan	074
Rendleman, Geo F, Jr.	St Louis	190
Rengachary, Dhanalakshmi	Kansas City	125
Rengachary, Setti S	Kansas City	125
Rennard, Marvin	St. Louis	190
Renner, Gregory J	Columbia	026
Renner, John H	Kansas City	125
Repp, Theodore J, Jr.	St. Louis	190
Revare, Paul	Kansas City	050
Revels, Harry , III	Leawood	125
Reyes, Efraim	Springfield	082
Reyes, Jose T	St. Louis	190
Reyes, Lirio M	Springfield	082
Reyes, Luis A	Arnold	190
Reynolds, James A	Chesterfield	190
Reynolds, Robert B, Sr.	Chesterfield	190
Reynolds, Susan K	St. Louis	190
Rezvani, Laghaieh	Sikeston	202
Rhee, Seoung E	Richmond	190
Rhoades, Charles E	Kansas City	125
Rhoads, Jack V	Joplin	102
Ribaudo, J. Michael	St. Louis	190
Ricci, Walter F	Kansas City	125
Rice, Karen H	Jefferson City	058
Rice, Kathleen G	Springfield	082
Rich, Keith M	St. Louis	190
Rich, Margaret M	St. Louis	190
Richards, Dean D, III	Kansas City	125
Richards, Frank O	St Louis	190
Richardson, Geo A	Union	074
Richardson, Marion W	Kansas City	125
Richardson, Thomas F	St Louis	190
Richardson, Wm R	Union	074
Richert, Robert C	Kansas City	125
Ridenhour, E. Gene	Columbia	026
Ridgeway, Wm G	St. Louis	190
Ridings, Harold D	Cape Girardeau	042
Ries, Douglas A	Chesterfield	190
Rigolosi, Ronald A	Kansas City	125
Rikli, Arthur E	Columbia	026
Riley, Chas T	Richmond	118
Riley, Louis T	Chesterfield	190
Riller, Lowell E	Kansas City	125
Rinck, Edward C	Nevada	214
Rinehart, Gregory C	St. Louis	190
Riner, Ronald N	St. Louis	190
Ringer, C. Nelson	Cape Girardeau	042
Riojas, Lisa A	Shawnee	215
Rippe, William F	St. Joseph	030
Rippey, John H	Kansas City	125
Rising, Dean R	Springfield	082
Ritter, C J	Cape Girardeau	042
Ritter, Carl F	Cape Girardeau	042
Ritter, Hubert A	St. Louis	190
Ritter, R. August	Overland	215
Ritter, Ray A, Jr	Cape Girardeau	042
Ritter, Raymond A, Sr.	Cape Girardeau	042
Ritter, William S	Kansas City	125
Rizzo, Adolfo E	St. Louis	190
Robb, Christine A	Grandview	125
Robbins, Philip L	St Louis	190
Robbins, Thomas D	Jefferson City	058
Roberts, Charles C	Kansas City	125
Roberts, Fred F	Kansas City	125
Roberts, Grosvenor G	Kansas City	125
Roberts, Harold K	Clayton	190
Roberts, Howard H	Joplin	102
Roberts, John P	St. Louis	190
Roberts, Perry T	Cape Girardeau	042
Roberts, Phyllis G	St Joseph	030
Roberts, Shauna R	Easton	030
Roberts, Theodore W	Sikeston	202
Robertson, Frank G	Cuba	190
Robertson, Wm D	Poplar Bluff	034
Robinett, Wade V	Kansas City	125
Robinson, Arthur W	Shawnee Mission	125
Robinson, Edith C	St Louis	190
Robinson, Gary L	Springfield	082
Robinson, Jay G	Kansas City	125
Robinson, Nicholas F	Kennett	070
Robinson, Ronald L	Cape Girardeau	042
Robinson, Van M	Marshall	198
Robinson, William A	Kansas City	125
Robinson, Wm J	Overland Park	125
Roblee, Melvin A	Richmond	190
Rockwell, Wayne L	Mission Hills	050
Rodefeld, Mark D	St. Louis	215
Rodes, Ned D	Mexico	014
Rodgers, Dorothy L	Columbia	026
Rodgers, George H	Leawood	125
Rodgers, Nancy T	St. Louis	215
Rodgers, Saml U	Kansas City	125
Rodrigo, Bernardo R	St. Louis	190
Rodriguez, Gregorio L	Charleston	202
Rodriguez, Raymond L	Ballwin	215
Rodriguez, Ubaldo R	St Louis	190
Roedel, Kathryn R	Sedalia	178
Roehrs, David H	Sedalia	178
Roehrs, Marvin E	Marshall	198
Rofail, Amin A	Shawnee Mission	125
Rogers, David B	Springfield	082
Rogers, H. Bryan	St. Louis	190
Rogers, James T	Springfield	082
Rogers, James D	Springfield	082
Rogers, John T	St. Joseph	030
Rogers, Joseph Drewry	Springfield	082
Rogers, Robt L	Kansas City	125
Roh, Joseph J	Independence	125
Roh, Lynn H	Kansas City	125
Rohatgi, Reeta	Cape Girardeau	042
***Roitman, Martin J**	Bridgeton	190
Roller, James A	Columbia	026
Rollo, John L	St. Louis	190
Romaker, Ann M	Kansas City	125
Romanace, Jean P	Mt. Vernon	166
Romeo, Joe	St. Louis	215
Romkema, George E	St. Louis	190
Rope, Douglas M	Kansas City	125
Roper, Charles L	St Louis	190
Rose, John F	Chillicothe	078
Rosecan, Marvin	Belleville	190
Roselman, Michael J	Springfield	082
Rosen, Charles B	Kansas City	125
Rosen, Howard M	Kansas City	125

---

*Doctor of osteopathy.

Rosen, Larry A	Independence	125
Rosen, William K	Springfield	082
Rosenbaum, Harry D	St. Louis	190
Rosenbaum, Herbert E	St. Louis	190
Rosenberg, David S	Florissant	190
Rosenbloom, Michael	St. Louis	190
Rosenblum, Barry N	St. Louis	190
Rosenquist, Chris R	Cape Girardeau	042
Rosenthal, Debra D	St. Louis	190
Rosenthal, Randall	St. Louis	190
Rosenthal, William N	Kansas City	125
Rosenwasser, Tamzin A	St. Louis	190
Ross, Gilbert , Jr.	Columbia	026
Ross, Robert M	Kansas City	125
Ross, Ryia	University City	215
Ross, Wm J	Bridgeton	190
Rossiter, Thomas W	St. Charles	215
Roter, Alexander M	St Charles	189
Roth, Alfred D	Mission	125
Roth, John J	St. Louis	190
Rother, Paul H	St Charles	189
Rothweiler, Robert J	St. Louis	190
Rotskoff, Kenneth S	St. Louis	190
Rottler, Paul D	Fenton	190
Roulhac, George E	Sea Island	190
Rouse, Ernest T, III	St Louis	190
Rouse, Ernest T	St. Louis	190
Roush, Randall D	Florissant	190
Routburg, Mark S	St. Louis	002
*Routsong, Rodney T	St. Louis	190
Rowe, Vernon D, III	Kansas City	125
Rowland, J. Christopher	Lee's Summit	125
Roxas, Generoso P	St. Charles	189
Roy, Tapankumar S	St. Louis	190
Royce, Debra L	Sarcoxie	102
Royce, James J	Sarcoxie	102
Rozen, Jay I	Kansas City	125
Rubin, Brian G	St. Louis	190
Rubin, Bruce K	St.Louis	002
Rubnitz, Leon H	Kansas City	125
Ruehl, Albert F	St Louis	190
Rues, Lawrence A	Kansas City	125
Ruess, Robert W	Cape Girardeau	042
Ruff, Paul G	Springfield	082
Ruhling, Rudy	Punta Gorda	190
Rumpf, Michelle R	Kansas City	215
Runez, Manuel W	Maryville	158
Runnels, James H	St. Louis	215
Ruocco, Eric M	Kansas City	215
Russell, Barbara E	Rolla	135
Russell, Garth S	Columbia	026
Russell, James L	Kansas City	125
Russell, Nancy R	Kansas City	050
*Russell, Robert B	Cape Girardeau	042
Russell, Robt K	Kansas City	125
Russell, Steven L	Liberty	050
Russell, Trent	St. Louis	215
Rusterholz, Joyce E	Middletown	190
Rutherford, Barry D	Kansas City	125
Rutherford, James L	St. Louis	190
Ruwitch, Joseph F, Jr.	St Louis	190
Ryall, Jo-Ellyn M	St. Louis	190
Ryan, David	Trenton	078
Ryan, Robert A	Pharr	082
Ryan, Robt E, Sr.	Chesterfield	190
Ryan, Thomas J	Jefferson City	058
*Ryan, Timothy J	Overland Park	215
Rymer, Marilyn M	Kansas City	125
Ryser, Carol A	Kansas City	125

S

Sabahi, Houman	St. Joseph	030
Sabapathy, Shawn	Joplin	102
Sabates, Felix N	Kansas City	125
Sabates, Roland	Kansas City	125
Sabatino, Anthony	Kansas City	002
Sabet, Abdollah A	Ballwin	190
*Sacha, Robert F	Cape Girardeau	042
Sachar, Jerome D	St. Louis	190
Sachar, Leo A	St. Louis	190
Sadhu, Vijay K	Columbia	026
Saferstein, A L	Shawnee Mission	125
Safley, Thos J	Independence	125
Saghir, Marcel T	St Louis	190
Saha, Debabrata	Columbia	215
Saha, Nitai C	St. Louis	190
Saha, Sudha R	St. Louis	190
Sakmar, Douglas A	St. Louis	190
Salanski, Stephen C	Lee's Summit	125
Sale, Llewellyn , Jr.	St. Louis	190
*Saleh, George A	Kansas City	050
Salinas, Mario	St. Louis	190
Salmon, M. L.	St. Louis	190
Salvador, Antonio	St. Louis	190
Salvaggio, Bruce H	Kansas City	125
Samet, John M	St. Louis	190
Sammon, T James	Springfield	082
Sammons, Harry C	Hermann	190
Samson, Barry L	St. Louis	190
Samudrala, Ramulu	St. Louis	190
Samuel, George P	Doniphan	034
Sanchez, Abelardo B	St. Louis	190
Sanchez, Guadalupe	St. Peters	189
Sanchez, Jon J	Springfield	082
Sand, John J	Kansas City	125
Sandberg, Chris B	St. Joseph	030
Sanders, Harold L	Columbia	026
Sanders, Jack S	Jefferson City	058
Sanders, Theodore E	St Louis	190
Sanders, Wm F	Kansas City	125
Sandow, Theodore L	Kansas City	125
Sandza, Joseph G, Jr.	Des Peres	190
Saneman, Paul P	Joplin	102
Santanello, William M	Belleville	190
Santiago, Felix R	Wilmington	206
Santillano, Antonio B	St Louis	190
Santos, Divina J	St. Louis	190
Sargent, Alden P	Sikeston	202
Sarma, Anuradha H	Kansas City	215
Sasser, Wm F	St Louis	190
Sata, Lindbergh S	St. Louis	190
Satake, Robert L	Kansas City	125
Sato, Geo	Chesterfield	190
Sato, Richard W	Chesterfield	190
Satterlee, C. Craig	Kansas City	125
Sauer, Donald C	St. Louis	190
Sauer, Gordon C	Kansas City	125
Sauer, James M	Springfield	082
Sauer, Paul E	Springfield	082
Sauls, David J	St. Louis	215
Sauvage, Jacques P	St Louis	190
Savci, Hasan D.	St Louis	190
Sawyer, Floyd E	Ft. Lauderdale	050
Sawyer, James	St. Louis	190
Saxon, Keith G	Liberty	125
Scacewater, Rick	Joplin	102
Scagliotti, Daniel	Kansas City	125
Scanlon, Charlotte D	Kansas City	125
*Scanlon, Robert C, II	Springfield	082
Scarborough, Betty F	Shawnee Mission	125
Scarborough, Mark R	Kansas City	125
Scariano, Lawrence A	Creve Coeur	215
Scearce, Robert L	Jefferson City	058
Schaaf, Robert O	Gower	030
Schaberg, James E	St. Charles	189
Schaberg, Kevin B	Chesterfield	190
Schacht, Lawrence R	Lake St. Louis	002
Schaefer, Glennon S	St Louis	190
Schaeffer, Edward M	Springfield	082
Schaerer, Jacques P	St. Louis	190
Schanbacher, Mary E	Kansas City	215
Schane, Catherine L	Springfield	082
Schanzlin, David J	St. Louis	190
Schaper, Ernest H	St. Louis	190
Scharf, Daniel	Kansas City	125
Scheele, Paul M	St. Louis	190
Scheer, George E	St. Louis	190
Scheer, Michael F	Columbia	215
Scheff, Robert J	St. Louis	190

---

*Doctor of osteopathy.

Scheibe, Robert G	St. Louis	190
Scheible, Robert F	St Louis	190
*Schekorra, Fred W	Camdenton	058
Schell, James A	Columbia	026
Scherer, Stephen	Kansas City	125
Scherr, David D	Jefferson City	058
Schertz, Truman B	N Kansas City	050
Scheu, James H	St. Peters	190
Schewe, Elmer J	Columbia	026
Schierman, Wm D	St. Louis	190
Schiffmacher, Jack E	Prairie Village	125
Schillie, Gene A	Kansas City	125
Schlafly, Bruce S	St. Louis	190
Schlafly, Edward F, Jr.	Chesterfield	190
Schlansky, Howard J	St. Charles	189
Schlansky, Seymour M	St. Louis	190
Schlarman, David E	St. Louis	190
Schlehr, Frank J	Kansas City	002
Schlossman, David M	Columbia	026
Schlozman, Danl L	Kansas City	125
Schmid, Tania L	St. Louis	190
Schmidt, Dennis A	St Louis	190
Schmidt, Edwin H, III	St. Louis	190
Schmidt, Edwin H	St Louis	190
Schmidt, Jerome H	Jefferson City	058
Schmidt, Marcus I	Lenexa	215
Schmidt, Martin P	St. Louis	190
Schmidt, Thomas L	Kansas City	125
Schmitt, Philip J	St. Louis	190
Schmitz, John M	Kansas City	125
Schmitz, Ralph A	Monett	166
Schnarr, William	St. Charles	189
Schneider, Alan R	St. Louis	190
Schneider, Douglas A	Lee's Summit	002
Schneider, F. David	Columbia	215
Schneider, Horace L	Cape Girardeau	042
Schneider, J. Michael	Springfield	082
Schneider, Paul G	St. Louis	190
Schneider, Robert J	St. Louis	190
Schneider, Sally L	St. Louis	190
Schneider, Thos A	St Charles	189
Schnurr, Thomas C	Neosho	166
Schoch, Lawrence H	Florissant	190
Schoeck, Albert F	Chesterfield	190
Schoenberger, John R	Cape Girardeau	042
Schoenecker, Perry L	St. Louis	190
*Schoenfeld, Roger H	Joplin	102
Schoengarth, Lowell D	Columbia	026
Schoentag, John S	St. Louis	190
Schokker, Johannes	Jefferson City	058
Schondelmeyer, R. Wade	Columbia	046
Schonfeld, Gustav	St Louis	190
Schoolman, Arnold	Kansas City	125
Schoonmaker, Gene	Springfield	082
Schopp, Alvin C	St Louis	190
Schottman, Gerhard W	Kansas City	125
Schranck, Chas R, Sr.	St. Louis	190
Schreiber, David J	Alton	190
Schrick, Richard E	St. Louis	190
Schroeder, Gerard R	Cape Girardeau	042
Schroeder, Robert E	Webster Groves	215
Schroeder, Walter A, Jr.	Cape Girardeau	042
Schroff, Carle E	Springfield	082
Schuessler, Edward C	St. Louis	190
Schuessler, Wolfgang P	St Louis	190
Schuetz, Alfred	St Charles	189
Schuetz, Evelyne G	St. Charles	189
Schuh, Marlys E	Creve Coeur	190
Schulman, Jeffrey I	St. Louis	190
Schultz, Earl R	St Louis	190
Schultz, Irwin	St Louis	190
Schulz, Richard C	St Louis	190
Schutz, John P	Excelsior Sprgs	050
Schwartz, Henry G	St. Louis	190
Schwartz, Howard R	Springfield	082
Schwartz, Howard I	Kansas City	125
Schwartz, Melvin M	St. Louis	190
Schwartzman, Neil R	Lebanon	115
*Schwarze, Robert F	Florissant	190
Schwegler, Robert G	Shawnee Mission	125
Schweiss, John F	St. Louis	190
Schweitzer, James M	St. Louis	190
Scodary, Daniel J	St. Louis	190
Scott, Andrew	Kansas City	125
Scott, C. Alan	Marshall	198
Scott, E. David	Jefferson City	058
Scott, Elwin P	Webster Groves	190
Scott, Jamie A	Springfield	082
Scott, Joni C	Springfield	082
Scott, Kenneth F	Clinton	086
Scott, Michael R	Springfield	082
Scott, Robert W	Springfield	082
Scott, Thomas E	Kansas City	125
Scott, Wendell J	Springfield	082
Scowley, John E	Richmond	118
Scully, Bruce D	Clinton	214
Scully, Thomas F	St. Louis	190
Seabaugh, Janice L	Mexico	014
Seabaugh, Wm L	Cape Girardeau	042
Seagrave, Richard A	Springfield	082
Seale, Stuart A	Springfield	082
Sedgwick, William G	St. Louis	190
See, W. Mike	Columbia	026
Seeck, Linda E	Washington	074
Seed, John C	St Louis	190
Seely, Clark W	Shawnee Mission	125
Segraves, Steven D	Kansas City	125
Seiden, Gerald D	Kansas City	125
Seitz, Elson F	Independence	125
Selhorst, John B	St. Louis	190
Seligman, Morris H	Maryland Hghts	215
Seligson, Frederic L	Kansas City	125
Sells, Kenneth J	Kansas City	125
Seralathan, Ramasamy	Trenton	078
Sertl, George O	St Louis	190
Sertl, James F	St Louis	190
Seshumurty, Ponnuru	Mission	125
Seshumurty, Vimala	Overland Park	125
Sessions, Donald G	St. Louis	190
Seto, Takeshi	Kansas City	215
Sexton, Daniel L	St. Louis	190
Shackter, Bruce I	Springfield	082
Shaeffer, James T	Springfield	082
Shafer, Kenneth E	West Plains	206
Shagets, Frank W	Joplin	102
Shah, Anwar	St. Louis	190
Shah, Jitendra P	St. Louis	190
Shah, Modaser	St. Louis	190
Shah, Narendra	St. Joseph	030
Shah, Ramesh R	Joplin	102
Shah, Sheila	St. Joseph	030
Shahan, Philip T	St. Louis	190
Shaikun, Gerald L	St. Charles	190
Shakil, Mohammad	Cape Girardeau	042
Shalet, Malcolm F	Kansas City	125
Shanahan, Mary P	Joplin	102
Shanahan, Philip J	St. Louis	190
Shands, Courtney , III	St. Louis	190
Shane, Ramon A	Springfield	082
Shaner, Thomas P	St Louis	190
Shank, Robert E	St Louis	190
Shapero, James A	Columbia	026
Shapiro, A. James	Springfield	082
Shapiro, Craig S	Kansas City	215
Shapleigh, John B, II	Chesterfield	190
Shaplin, Alfred D	Ballwin	106
Sharma, Vidya	Kansas City	125
Sharp, Austin R	Ballwin	190
Sharp, Ronald J	Overland Park	125
Shatz, Burton A	St Louis	190
Shaw, David A	Rolla	135
Shaw, James T	Hermann	074
Shaw, Richard C	St Louis	190
Shaw, Robert D	Willow Springs	206
Shea, James G	Washington	074
Sheahon, John A	Raytown	125
Shealy, C. Norman	Springfield	082
Shechter, Nathan	Kansas City	125
Sheehan, Michael B	Kansas City	125
Sheehan, Paul J	Bridgeton	190

---

*Doctor of osteopathy.

Sheffner, Paul W	St. Louis	190
Shehadi, Sameer I	St. Louis	190
Shelden, Russell D	Kansas City	125
Shell, William C	Sikeston	202
Shelley, William C	Kansas City	125
Shelso, John H	St. Louis	215
Shelton, Becky R	Chesterfield	190
Shelton, R. Wayne	Springfield	082
Shen, Anthony S	St. Louis	190
Shen, Jerome T	St Louis	190
Shen, Winston W	St. Louis	190
Sher, Allyn L	Columbia	026
Sheridan, John J	St Louis	190
Sherman, Thomas M	St. Louis	215
Sherman, W. Gary	Chesterfield	190
Sherrod, Charles F	Joplin	102
Sherrod, Duane W	Joplin	102
***Sherrod, Glenn M**	Bridgeton	190
Sherwin, Charles S	St. Louis	190
Sheverini, James A	Kansas City	125
Shevlin, Chas F	Palm Springs	030
Shieber, Wm	St. Louis	190
Shields, John B	St. Louis	190
Shields, Lawrence S	Springfield	082
Shifrin, Alexander	Kansas City	125
Shimshak, Thomas M	Kansas City	125
Shine, Thomas E	St. Louis	190
Shinn, Michael E	Kansas City	050
***Shipman, Wade M**	Springfield	082
Shitut, Ravindra V	St. Louis	190
Shively, Raymond E	St. Louis	190
Shively, Robert A	St. Louis	190
Shockley, Clarence J	Greenwood	125
Shook, John W	Kansas City	125
Shore, Bernard L	St. Louis	190
Short, Charles D	St. Louis	190
Short, Howard N	Washington	074
Shoss, Milton	Hilton Head Isl	042
Shoults, Nicholas F	Springfield	082
Shull, G D	Jefferson City	058
Shultz, Thomas M	Springfield	082
Shuman, Joseph S	Creve Coeur	190
Shuman, Robert B	St. Louis	190
Shuttari, Mir F	Columbia	190
Shyken, Herman	St. Louis	190
Sicard, Gregorio A	St. Louis	190
Sicat, Alfonso V	Warrensburg	110
Siddiqui, Farzanna Q	Woodriver	190
Sides, Stanley D	Cape Girardeau	042
Sides, Stephen N	Olathe	215
Siegel, Barry A	St. Louis	190
Siegel, Carl D	Kansas City	125
Siegel, Charles	Gladstone	050
Siemers, Geo E	PortageDesSioux	190
Siesener, Herbert H	St. Louis	190
Siffring, Corydon W	St. Charles	215
Sigmund, Charles A	Bridgeton	190
Silber, Sherman J	Chesterfield	190
Siler, Thomas M	St. Charles	189
***Sill, William**	St Peters	189
Silliman, York E	St Joseph	030
Silsby, Harry D	Springfield	082
Silver, Bernd	St Louis	190
Silver, Donald	Columbia	026
Silverberg, Bruce	St. Louis	002
Silverberg, Charles	St. Louis	190
Silvers, L. Michael	Kansas City	125
Silverstein, Steven M	Independence	125
Simmons, Donald D	Kansas City	125
Simmons, Jess S	Joplin	102
Simmons, John L	Vero Beach	125
Simo, Frank	St. Louis	190
Simon, David L	St. Louis	190
Simon, Gracita S	Smithville	050
Simon, Nathan M	St. Louis	190
Simon, Sanford	Kansas City	125
Simons, Paul S	St. Louis	190
Simowitz, Fredric M	St. Louis	189
Simpson, Albert P	Springfield	082
***Simpson, Floyd D**	Springfield	082
Simpson, Joseph	St. Louis	190
Sincox, Chas H	Washington	074
Singh, Daljeet R	Higginsville	118
Singh, Kuldeep	Macon	046
Singhal, Gokul C	St Louis	190
Singleton, John M, III	Kansas City	125
Singleton, Marvin A	Joplin	102
Sinnett, Mark F	Kansas City	125
Siripipat, Pallop	Mexico	014
Sisk, James C	St. Louis	190
Sislen, Donald R	St Louis	190
Sisler, Maynard L	Kennett	070
Sisson, Richard G	St. Louis	190
Sitzman, Everette T	Kansas City	125
Sitzmann, Bryan L	Kansas City	050
Siu, Kenneth K C	Jefferson City	058
Skeins, Edward J, Jr.	Springfield	082
Skelley, Mark J	Joplin	102
Skibba, Joseph L	Columbia	026
Skillman, Robt K	Kansas City	125
Skimming, W. Lee	St. Louis	190
Skinner, John S	St. Louis	190
Skinner, John T	Kansas City	125
Sklenar, Donald E	St. Joseph	030
Skor, Donald A	St. Louis	190
Sky, Adam J	St. Louis	215
Slack, Melinda R	Springfield	082
Slahorek, George J	Ft Leonard Wood	135
Slankard, J E	Kansas City	125
Slaughter, Carl R	Morrilton	050
Slaughter, Larry	Columbia	215
Slentz, Edwin L	Shawnee Mission	125
Slentz, Wm A	Overland Park	125
Sletten, Ivan W	St Louis	190
Slimack, Joseph P	St.Louis	002
Slocum, Stephen G	St. Louis	190
Sly, Anne K	Kansas City	125
Smeltzer, Frederick M	Osage Beach	120
Smid, Anne A	Springfield	082
Smid, David M	Springfield	082
Smiley, William L	St. Louis	190
Smit, Herbert M	St. Louis	190
Smith, Arthur B	Philadelphia	125
Smith, Benj F	Kirkwood	190
Smith, Brenda S	Kansas City	125
Smith, Bruce D	St. Joseph	030
Smith, C. Byron , III	Kansas City	125
***Smith, C. Daniel**	St. Joseph	030
***Smith, Charles H**	Gladstone	050
Smith, Claude F	Willow Springs	206
Smith, David Lambuth	Kansas City	125
Smith, Dennis W	Joplin	102
Smith, Dermott A	St. Louis	190
Smith, Elbert E	Kansas City	125
Smith, Emily L	St Louis	190
Smith, Garland F	St. Louis	190
Smith, Gilbert D	Poplar Bluff	034
Smith, Herbert P	West Palm Beach	190
Smith, Hubert E	Kansas City	125
Smith, Hugh R	St. Louis	190
Smith, J. Ned	Columbia	026
Smith, James B	St. Louis	190
Smith, Katherine W	Kansas City	125
Smith, Kathleen	DuQuoin	190
Smith, Kenneth R, Jr.	St. Louis	190
Smith, Kenneth R	West Plains	206
Smith, Kenneth B	Washington	074
Smith, Michael J	Liberty	215
Smith, Morton E	St. Louis	190
Smith, O. Dale	Shawnee Mission	125
Smith, Patrick A	Columbia	026
Smith, Peter G	St. Louis	190
Smith, Porter	Kennett	070
Smith, Ralph O	Jefferson City	074
Smith, Reid C	Kansas City	125
Smith, Ricky A	Sikeston	202
Smith, Robert W	St Louis	190
Smith, Robt W	Brookfield	078
Smith, Roland T	Gulfport	102
***Smith, Toni R**	Kirksville	148

---

*Doctor of osteopathy.

Smith, W. Russell	Carthage	102
Smith, Wallace B	Independence	125
Smith, Wm J	Windsor	086
Smolik, Martin J, Jr.	Joplin	102
Smoller, Martin B	St Louis	189
Snavely, Sharon R	Kansas City	125
Snead, William H	Springfield	082
Sneid, David S	Kansas City	125
Snider, Gregory T	St. Louis	215
Snidle, William F	Crystal City	106
Snodgrass, Joe E	Kansas City	215
Snow, Emasue	Springfield	082
Snow, Jon F	Springfield	082
Snowden, Kent L	St. Louis	190
Snyder, Christopher H, Jr	Springfield	082
Sobky, George H	Louisiana	190
Soha, Joseph J, Jr.	Columbia	026
Sohn, Richard	St Louis	190
Solanki, Nareshkumar J	Wentzville	190
Sollars, Eric G	St. Joseph	030
Solomon, Felix G	St. Louis	190
Solomon, Harvey	St. Louis	190
Soltys, Stephen M	Columbia	026
Somers, Michael E	N. Kansas City	050
Sommer, Conrad S	St. Louis	190
Sommer, Rand W	St. Louis	002
Somoza, Jose R	Kansas City	050
Soonattrakul, Wuthisak	Kennett	070
Soorya, Narendir T	St. Louis	190
Soper, Wm D	Liberty	125
Sopuch, John A	St. Ann	190
Sosebee, Lee A	Columbia	026
Sosna, Jacob P	St. Louis	190
Soto, Albert A	St. Louis	190
Soucie, Carol J	Arnold	002
Soucy, John C	St Charles	189
Southwick, Christopher L	Columbia	026
Sowash, James J	Columbia	026
Spadaro, James J	St. Louis	190
Spade, Diana J	Springfield	082
Spake, R. Vanneman	Kansas City	125
Spalding, David L	Springfield	082
Spalding, Donald G	St. Louis	190
Spalding, Wilber B, Jr.	Kansas City	125
Sparkman, Thomas C	Cape Girardeau	042
Spearman, Paul W	Kirkwood	215
Speckman, Jerry M	Kansas City	125
Spector, Gene W	St. Louis	190
Spector, Gershon	St Louis	190
Spence, Paul A	Cape Girardeau	042
Spence, Thomas H, Jr.	St. Louis	190
Spencer, Donald M	Kansas City	125
Spencer, Donald C	Fulton	038
Speno, Angelo A	St. Louis	190
Spernoga, John F	St. Louis	190
Spewak, Robert D	St. Louis	190
Spies, Barbara J	Louisburg	125
Spitler, Allen L	Cape Girardeau	042
Spivack, Alan R	Chesterfield	190
Spoeneman, Marlin C	Jacksonville	190
Spollen, Linda E	Columbia	026
Sponenberg, Don D	Springfield	082
Sportsman, Weldon L	Kansas City	050
Spradlin, Larry D	Kansas City	125
Sprague, Gita	St. Joseph	030
Spray, Thomas L	St. Louis	190
Spriegel, John R	Stevensville	190
Springer, David D	Monroe	215
Spurgeon, Milo J	Columbia	026
Spurgeon, Stephen	St. Louis	190
Spurney, Joe E	Kansas City	125
Spurny, Otto M	Kansas City	125
Spurrier, Mark H	St. Louis	190
Squitieri, Alphonse J	St. Louis	190
Srivisal, Somnuk	St. Louis	190
St. John, Donald R	Marshall	102
Staab, Gerald E	Kansas City	125
Stacey, Wallace R	Independence	125
Stafford, Walter R	St. Louis	190
Stahl, Lloyd D	Kansas City	125
*Stahly, Randall L	Cape Girardeau	042
Stahr, William D	Cape Girardeau	042
Stallard, Donald J	St. Joseph	030
Stamatis, John J	Springfield	082
Standiford, Steven B	Columbia	026
Stanford, Carol A	Kansas City	125
Stanley, Charles G	Kansas City	125
Stanley, John H	Kansas City	125
Stark, Karl R	Kansas City	125
Starke, Keith M	St. Louis	190
Starkloff, Gene B	Ballwin	190
Starks, Gregory C	Kansas City	125
Statland, Harry	Kansas City	125
Statland, Morris	Shawnee Mission	125
Stauder, Thomas J	Cincinnati	215
Stauffer, Harry B	Jefferson City	058
Stauffer, Larry K	Jefferson City	058
Stavrides, Pete D	St. Louis	190
Steele, Jeffrey S	Cape Girardeau	042
Steele, Mark T	Kansas City	002
Steenbergen, Michael	Jefferson City	058
Steffen, Lawrence F	Shawnee Mission	125
Steigman, Carmen K	St.Louis	002
Steiling, Sylvia A	St. Louis	190
Steiman, Barry	Creve Coeur	189
Stein, Harry J	St. Louis	190
Steinberg, Franz U	St Louis	190
Steinberger, Robert	Rocky Mount	074
*Steinbrecher, Janis M	Lee's Summit	125
Steiner, Alexander J	St. Louis	190
Steiner, Marvin P	Independence	002
Steinhardt, George F	St. Louis	190
Steinhaus, David M	Kansas City	125
Stell, Juliette A	Rogersville	215
Stelmach, Walter J	Kansas City	125
Stelnicki, Eric J	Chesterfield	215
Stephen, C. Ronald	Chesterfield	190
Stephenson, Hugh E	Columbia	026
Stephenson, Robert E	Overland Park	125
Stepp, Timothy E	Kansas City	125
Sterkel, Barbara B	St. Louis	190
Sterkel, Richard L	St. Louis	190
Sterns, Jordan B	Clayton	215
Stevens, Edward M	St. Joseph	030
Stevens, Tracy L	Kansas City	215
Stewart, Harry A	Kansas City	125
Stewart, James G	Kirkwood	190
Stewart, James L	Weatherby Lake	050
Stewart, L. Paul	St. Louis	190
Stewart, Robt B	Springfield	082
Stewart, Ronald M	Kansas City	125
Stewart, Wendell	Springfield	082
Stiaszny, Louis K	Kansas City	125
Stickle, Arthur W	St. Louis	190
Stickley, Louis P	St Louis	190
Stiffman, Michael N	Columbia	215
Stiles, Michael C	Kansas City	125
*Stillie, G. Donald	Kansas City	125
Stillings, Wayne A	St. Louis	190
Stine, G. Wayne	Springfield	082
Stith, John A	St. Louis	190
Stitt, Ronald W, Jr.	Kansas City	125
Stockton, Raymond W	Shawnee Mission	125
Stockwood, Robt C	Sedalia	178
Stoecker, Willeford J	Cape Girardeau	042
Stoecker, William V	Rolla	135
Stohr, Paul E	St. Charles	190
Stokes, Douglas L	St. Joseph	030
Stokes, James M	St. Louis	190
Stoliar, Bruce	St. Louis	190
Stone, Kenneth D	Sikeston	202
Stone, Mary K	Blue Springs	125
Stoneman, William , III	St Louis	190
Stoops, Stephen L	Kansas City	125
Stout, Carl N	Independence	125
Stoy, Robt P	Columbia	026
Stradford, H. Todd	Columbia	026
Stratemeier, Edward H	Blue Springs	125
Straub, David L	Joplin	102

---

*Doctor of osteopathy.

Strauss, Carl F	Kansas City	125
Strecker, William B	St. Louis	190
Stribling, Thos L	Independence	125
Stricker, Eamil A	Rolla	135
Stricker, William E	Rolla	135
Strickland, James C	St. Louis	190
Stringer, Kenton L	Aurora	166
***Stringer, Robert F**	Joplin	102
Strobach, Kurt F	St. Louis	190
Stroble, Mark	St. Louis	190
***Stroemel, Mathias M**	Kansas City	215
Stromberg, Brent V	St. Louis	190
Stromberg, Eric D	Kansas City	125
Stronach, Linda L	St. Louis	190
Stronsky, David	St. Louis	190
Stroud, Malcolm H	Dallas	190
Strunk, Robert C	St. Louis	002
Stryker, William I	Osprey	190
Stuart, Byron M	Boonville	026
Stuart, Danl D	Brunswick	046
Stubbs, Thomas R	West Plains	206
Stuber, Robert R	St. Joseph	030
Stuckmeyer, James A	Blue Springs	125
Stuebner, Roland W	Kirkland	190
Stuerman, Lawrence G	Louisiana	186
Stufflebam, Brian W	St. Peters	189
Stufflebam, Robt E	Springfield	082
Stuppy, Mark S	Springfield	082
Sturtevant, Harwood N	Springfield	082
Su, Charles Y	Prairie Village	215
Su, Philo S	Jefferson City	058
Suarez, Alberto	Lee's Summit	125
Suarez-Solar, Pedro L	St Charles	189
Subramanian, S.	Carthage	102
Suddarth, Sterling B	Kansas City	125
Sudekum, Joseph M	St Louis	190
Sueper, Robert H	St. Louis	190
Sugarbaker, Everett D	Jefferson City	058
Sull, Won-Jong	Sedalia	178
Sullivan, Bradley H	Kansas City	125
Sullivan, Christine	Overland Park	125
Sullivan, Dan T	Springfield	082
Sullivan, James H	Mission	215
Sullivan, John A	Springfield	082
Sullivan, William W	St. Louis	190
Sultan, Tipu	Florissant	190
Sumer, Cengiz M	Bridgeton	190
Sumer, Emel A	Bridgeton	190
Summers, John B	St. Louis	190
Summers, Jos S	Jefferson City	058
Summers, Thomas F	Olney	190
Sunderji, Shiraz	St. Louis	190
Sundermann, Richard H	St. Louis	190
Sundstrom, Frank D	Springfield	082
Sunshine, Herbert	St Louis	190
Suseela, Dasari	Kansas City	125
Susi, Jesse G	St. Louis	190
Sutherland, Charles J	St. Louis	190
***Suthoff, Jim**	Joplin	102
Sutphen, Eric J	St. Louis	190
Sutter, Richard A	St Louis	190
Suva, Morfeo M	Springfield	082
Suvan, R	Poplar Bluff	034
Suwanabhand, Chalaw	Butler	214
Suwannasri, Rudee	St. Louis	190
Swaim, Truett	Blue Springs	125
Swaney, Charles M	Columbia	026
Swanson, Eric	Kansas City	125
Swanson, Robert G	Ballwin	215
Swarens, Exec. Dir., C. C.	Jefferson City	001
Swaykus, Bernard T	Bridgeton	190
Sweeney, Michael J	Kansas City	125
Sweeney, Thos P	Springfield	082
Sweet, Robert A	Springfield	082
Sweiger, James H	Plattsburg	054
Swetnam, Jeffrey A	Dyersburg	166
Swinfard, Ronald W	Columbia	026
Sword, Suzanne H	Kansas City	125
Sylvanovich, W. Richard	St. Louis	190
Sylvester, James	Columbia	215
Syzek, Elizabeth J	Columbia	026
Szabados, Ernest D	Independence	125
Szewczyk, Michael J	Columbia	026
Szoko, Edward	St. Louis	190
Szymanski, Stanley R	Macon	078

T

Tackett, Russell E	Kansas City	125
Taege, Alan J	St. Joseph	030
Tailor, Chandrakant C	St. Louis	190
Takacs, Robert J	Kansas City	125
Talbert, Clifford R	Cape Girardeau	042
Talbott, Lawrence B	Kansas City	125
Talwar, Tara	Chesterfield	190
Tamblyn, Claire L	Tubac	125
Tanaka, Geo M	St Louis	190
Tang, Teodoro	Salem	135
Tanner, John P	Kansas City	125
Tanner, Robert H	Jefferson City	058
Tanphaichitr, Kongsak	St. Louis	190
Tansuwan, Chukiat	Ferguson	190
Taormina, Marc K	Independence	125
Tarantino, Celeste	Kansas City	002
Tariq, Manzoor A	Chesterfield	215
Tarneja, Kailash C	West Plains	206
Tate, Kara L	Kansas City	125
Tatkow, Robert W	St Louis	190
Taute, Hermann	St. Louis	190
Taylor, Eugene D	St. Louis	190
Taylor, John R.W.	Kansas City	125
Taylor, Leon A	Jefferson City	058
Taylor, Philip W	Cape Girardeau	042
Taylor, Steve J	Mexico	014
Taylor, William K	Springfield	082
Tayob, Anver A	St. Louis	190
Teague, Brettly J	Lenexa	215
***Tedrick, Phillip D**	Cape Girardeau	042
Tedrow, Jeffrey R	Bolivar	066
Teeter, Brian H	Joplin	102
Tekwani, Hiralal T	St Louis	190
Templer, Jerry W	Columbia	026
Tendai, Mark M	Springfield	082
Tenney, Jackie	Kansas City	125
Tenorio, Arturo A	Stanberry	158
Tenorio, Gene	Springfield	082
Tenorio, Genoveva	Albany	158
Tepper, Arnold	St Louis	190
Ternberg, Jessie L	St Louis	190
Terry, Boyd E	Columbia	026
Terry, James W	Cape Girardeau	042
Terry, James F	Springfield	082
Terschluse, David A	Bridgeton	190
Tess, Allen F	Florissant	190
Tess, Melvin J	St. Louis	190
Tessier, John E	St. Louis	190
***Tewis, Huey D**	Cape Girardeau	042
Thalblum, Harvey	Kansas City	125
Thale, Thomas R	Ballwin	190
Thawley, Stanley E	St Louis	190
Thedinger, Bradley S	Kansas City	125
Theel, Otto W, Jr.	Shawnee Mission	125
Thibeault, Donald W	Kansas City	125
Thiel, J. Allen	St Louis	190
Thiele, Belmont R	Las Vegas	190
Thiele, Otto K	St Charles	189
Thierauf, Charles G	St Louis	190
Thies, Jerome H	Osceola	214
Thoma, George E, Jr.	St. Louis	190
Thomas, Alexis G	Kansas City	125
Thomas, Christopher Y	Shawnee Mission	125
Thomas, Deborah G	Cape Girardeau	042
Thomas, F. Anthony	Kansas City	050
Thomas, Horace E	Columbia	026
Thomas, J. Regan	St. Louis	190
Thomas, James J	Kansas City	125
Thomas, Matthew A	St. Louis	190
***Thomas, Norvin E**	Mexico	014
Thomas, Robert M	Columbia	026
***Thomas-Richards, Jose R**	Kansas City	125

---

*Doctor of osteopathy.

Thomasson, David D	Springfield	082
Thomasson, Jeffrey L	St. Louis	190
Thomasson, Mary W	St. Louis	190
Thompson, David E	Independence	125
Thompson, Eric	Columbia	026
Thompson, F Gregg	St Joseph	030
Thompson, Frederick E	Liberty	050
Thompson, Frederick L	Nevada	214
Thompson, M. Bryant	Chesterfield	190
Thompson, Paul D	Cape Girardeau	042
Thompson, Robert F	Kansas City	125
Thompson, Scott W	Kansas City	125
Thompson, Susan	Plattsburg	054
Thompson, Exec V.P., James E	Springfield	001
Thornhill, Joseph M	St. Louis	215
Thornton, Fred H	Sikeston	202
Thornton, Michael K	St. Louis	215
Thorp, James A	Kansas City	125
Thorpe, William P	Cape Girardeau	042
Throne, Ben J	Kansas City	125
Thurman, Jerome E	St. Louis	215
Thurmann, Manfred	St Louis	190
Tice, Wayne K	Lee's Summit	125
Tichenor, Robert W	Fenton	190
Tiefenbrunn, Sharon F	St. Louis	190
Tietjen, Fred O	Osage Beach	120
Till, Bennie N	Poplar Bluff	034
Tillema, David A	Kansas City	125
Tillinghast, Jeffrey P	St. Louis	190
Tillman, Mary A	St. Louis	190
Tilson-Mallett, Nancy R	Kansas City	125
Tilzer, Seth	Florissant	190
Tindall, Robert N	Punta Gorda	190
Tinsley, John C	Columbia	026
Tio, Liep T	West Plains	206
Tiojanco, Milagros E	Kansas City	125
Tippett, Jack C	St. Louis	190
Tissier, Bradley J	St. Ann	190
Titterington, Frank W	Kansas City	125
Tobey, Albro C, Jr.	St. Louis	190
Tobin, Garry S	St. Louis	190
Tobin, Gregory A	Cape Girardeau	042
Tobin, Marla J	Higginsville	118
Tobin, Robert F	St Joseph	030
Tobler, Jerry	St. Louis	190
Tobler, Randall W	St. Louis	190
Tombridge, Thomas L	Springfield	082
Tominack, Rebecca L	St. Louis	190
Tomlinson, David L	Kansas City	125
Tompson, Robt V	Moberly	046
Torin, Bernice A	St Louis	190
Torontow, Raphael J	Nevada	214
Torrence, Ralph J	Bridgeton	190
Torres, Paul	Kansas City	050
Totty, William G	St. Louis	190
Toubes, Daniel B	Kansas City	125
Towle, Daniel J	Kansas City	125
Trachtenberg, Jeffrey D	St. Louis	215
Trammell, Lee W	Columbia	026
Traxel, Wm L	Poplar Bluff	034
Treadwell, Randall E	Alton	190
Trecha, Randal R	Columbia	026
Treiman, Robt C	St Louis	190
Trevor, Richard P	Kansas City	125
Trimble, Geo X	Kansas City	125
Trimmer, Jeanne M	St. Louis	190
Trinidad, Hermanito R	Chillicothe	078
Triplett, Daniel A	Liberty	050
Triska, Roland A	St. Louis	190
Trobough, Todd D	Shawnee Mission	215
Troeh, Melvin R	Independence	125
Trombold, Walter S	Kansas City	125
Troop, Bryan R	St. Louis	190
Trotta, Philip C	St. Louis	190
Trotter, Francis O, Jr.	Carrollton	190
Trotter, John L	St. Louis	190
Trotter, W. Yates	Springfield	082
Trowbridge, Barnard C	Prairie Village	125
Trowbridge, Denise R	Olathe	002
Trowbridge, Ellsworth	Sun City	125
True, James D	N. Kansas City	050
Trueblood, Alva C	St Louis	190
Trueblood, Michael C	Cape Girardeau	042
Trugly, Edith S	St. Louis	190
Tsai, Cheng C	St. Louis	002
Tsang, John L	Springfield	082
Tschudin, Garland	St. Louis	190
Tsen, Tony N	St Louis	215
Tsifutis, Argyrios A	Bridgeton	190
Tsolakoglou, Cleo	St.Louis	215
Tucker, Dolores R	Chesterfield	190
Tucker, Geo L	Chesterfield	190
Tucker, Leslie E	Washington	074
Tucker, Robert E	St. Louis	190
Tumanut, Benesto F	Gladstone	050
Tungsiripat, Soros	Kennett	070
Tuohy, Gerald F	Kansas City	125
Turano, Wm L	Raytown	125
Turfboer, Robert	Joplin	102
Turgeon, Ronald P	St. Louis	190
Turnbaugh, Thomas R	Jefferson City	046
Turner, Glenn O	Springfield	082
Turner, James D	Washington	074
Turner, Kirby L	Poplar Bluff	034
Turner, Marc A	Kansas City	125
Turner, Scott A	Osceola	214
*Turner, Timothy T	Barrington	002
Turner, William A	Nevada	214
Tutera, Dominic F	Kansas City	125
Tutera, Gino	Kansas City	125
Tuteur, Peter G	St. Louis	190
Tuttle, Jay F	Creve Coeur	138
Twardowski, Radomysl M	Columbia	215
Twedell, Donald L	St. Louis	190
Twyman, Richard A	Shawnee Mission	125
Tyler, Thomas D	Lexington	118
Tyndall, Robert J	Springfield	082
Tyree, Thomas A	St. Charles	215

U

Uchiyama, Robert C	Chesterfield	190
Uhlemann, John H	St Charles	189
Uhlemeyer, Henry A	St Louis	190
Uhrig, Jack R	Marshall	198
Uketui, Ozoemenam I	Kansas City	215
Umar, Ibrahim S	St. Charles	189
Underwood, Dick H	Leawood	125
Underwood, Johnson , III	Kansas City	050
Ungvari, Jos C	St Louis	190

V

Vacca, Jos B	St. Louis	190
Vadlamani, S. M.	St Louis	190
Vafi, Houshang	St Louis	190
Vajaranant, Manit	Lexington	118
Valach, Frank J	St. Louis	190
*Vale, Janett A	Kansas City	125
Vale, Janie R	Columbia	026
Valera, Salvador S	St. Joseph	030
Valtierra, Cesar A	Clayton	190
Valuck, Richard P, Jr.	Hannibal	150
Van Amburg, Albert L, III	Chesterfield	190
Van Biber, James T	Blue Springs	125
Van Buskirk, Wm C	Kansas City	125
Van Dyke, Elmer H	Sedalia	178
Van Norman, Robert T	St. Louis	190
Van Osdol, Kelvin D	Springfield	082
Van Ryn, Jacques S	Bridgeton	190
Van Voorn, Catherine M	Columbia	026
Van Way, Charles W, III	Kansas City	125
Van Zanten, Niko A	Osceola	214
Vandewalker, Mark L	Rolla	135
Vandivort, Paul M, Jr.	St. Louis	190
Vandover, John T	St Louis	190

---

*Doctor of osteopathy.

Vannier, Michael W	St. Louis	190
VanGoidsenhoven, Guy E	St Louis	190
VanVranken, Eugene E	Jefferson City	058
*Vardakis, Gregory M	Kansas City	215
Vargas, Theodoro C	Pacific	190
Varma, Devendra K	Poplar Bluff	034
Vatterott, Paul B, Jr.	Chesterfield	190
Vaughn, James W	Overland Park	125
Vaughters, Frank M	Kansas City	125
Veenstra, Sallie L	Lee's Summit	125
Velasco, Ernesto T	St. Louis	190
Venable, H. Phillip	Ballwin	190
Venneman, Charles R	Kansas City	125
*Venter, John L	Joplin	102
Vera, Enrique	Kansas City	125
Verde, Julian N	St. Louis	190
Verdught, Ammon L	Lee's Summit	125
Vergara, Gerardo G	Kansas City	125
Vernava, Anthony M, III	St. Louis	190
Verona, Montgomery A	Springfield	082
Verzola, Eufemio G	Herculaneum	106
Vesely, Thomas M	St. Louis	002
Vest, James C	St. Louis	190
*Vialle, Gene M	Kansas City	125
Viamontes, Jorge A	St Louis	190
Vibulakaopun, Pairat	Bonne Terre	138
Vickar, Garry M	Florissant	190
Vierling, Stephen E	St. Louis	190
Vierling, Timothy E	Moberly	046
Viers, Wayne A	St Louis	190
Vietti, Teresa J	St. Louis	002
Vighi, James R	St Charles	189
Vijungco, Jose G	St. Louis	190
Villafuerte, Nila A	Chesterfield	190
Villahermosa, Juanito L	Savannah	010
Villamar, Elizabeth N	St. Louis	190
Villanueva, Angela A	Overland Park	125
Villarama, Antonio P	High Ridge	190
Vilmer, Charles E	No. Kansas City	050
Vilmer, Stephen E	N. Kansas City	050
Vinyard, Jack L	Joplin	102
Virant, John A	St Louis	190
Viril, Leonardo C	Kansas City	125
Visner, Sandra L	Kansas City	002
Vitale, Anthony J	Chesterfield	190
Vitale, Nicholas S	St. Louis	190
Vitale, Stephen J	Ballwin	190
Vivian, Gary D	St. Peters	189
Viviano, Joseph G	Glendale	190
Vo, Thuy-Lieu T	St. Louis	002
Vogel, Arthur P	Shawnee Mission	125
Vogel, Curt M	Columbia	026
*Vogelsang, Judith K	Kansas City	125
*Volarich, David T	St. Louis	190
Vollmar, Lewis C, Jr.	St Louis	190
Vollmer, Dennis G	St. Louis	190
Voshall, David L	Blue Springs	002
Votaw, Robt E	St. Louis	190
Voth, Harold W	Shawnee Mission	125
Vournas, Christopher G	St. Louis	190
Vournas, George C	Bridgeton	190

W

Wachter, Ronald M	Springfield	082
Wacker, Leo L	St Louis	190
Waddell, Kenneth E	Springfield	082
Waddell, Thomas H	Kansas City	125
Wade, Kim C	Kansas City	125
Wade, Larry A	Springfield	082
Wadlow, Ernest E	St. Joseph	030
Wadsworth, Harry L	St. Louis	002
Waeckerle, Joseph F	Kansas City	125
Wagan, Primitiva C	St. Louis	190
Waggoner, Chas M	Columbia	026
Waggoner, Sharon E	St. Joseph	030
Wagman, Armin J	Springfield	082
Wagner, John R	St Louis	190
Wagner, Paul J	Greenwood	125
Waite, John G	St Louis	190
Wakeman, Newt , Jr	Springfield	082
Wald, Stanley M	St. Louis	190
Walden, James M	Kansas City	125
Waldorf, James C	Kansas City	125
Walentik, Corinne	St Louis	190
Walentynowicz, James E	St. Louis	190
Walker, Ambrose T	Thayer	206
*Walker, David Brooks	Bridgeton	190
Walker, Francis S	St Louis	190
Walker, Gary K	Springfield	082
Walker, Gregory E	Independence	125
Walker, Harvey , Jr.	St. Louis	190
Walker, J Leslie	St. Louis	190
Walker, Kent D	Columbia	215
Walker, Melvin O, Jr.	Springfield	082
Walker, Orville C	Independence	125
Walker, William M	Springfield	082
Wall, Harry C	Shawnee Mission	125
Wall, Joe A	Houston	206
Wall, Leonard A	Kansas City	125
Wall, Lester E	St. Louis	190
Wall, Norman R	Springfield	082
Wallace, Darryl L	Kansas City	125
Walley, Lynn J	Hannibal	150
Walline, T. Andrew	Kansas City	215
Walls, Earlene H	Kansas City	125
Walls, Joseph T	Columbia	026
Walsh, Andrew L, III	St. Louis	215
Walsh, Barbara A	St. Louis	190
Walsh, James W	St Louis	190
Walsh, Martin J	St. Charles	189
Walsh, Richard J	St. Joseph	030
Walter, William L	St Louis	190
Walters, Henry W	St. Louis	190
Waltman, Stephen R	St. Louis	190
Walton, J. Douglas	Sikeston	202
Walton, Patrick J	Kansas City	125
Waltz, James R	Liberty	050
Walz, Bruce J	St. Louis	190
Wan, Shaw P	Rolla	135
Wankum, Robert P	Jefferson City	058
Wantuck, Donald K	Springfield	082
Warady, Bradley A	Kansas City	125
Ward, Joe W	Lexington	118
Ward, Mark	Neosho	102
Wareing, Thomas H	St. Louis	002
Waring, J. Michael	Kansas City	125
Warres, Herbert L	Springfield	082
Warsinski, Ivy M	Maryville	190
*Wasserman, Gary S	Kansas City	125
Wasserman, Gary M	St. Louis	190
Wasserman, Helman C	St. Louis	190
Wasserman, Mark S	St. Louis	190
Waterfield, Jim R	Springfield	082
Waterman, Franklin M	Kansas City	050
Waters, Hugh R	Chesterfield	190
Waters, Jeffrey A	Kansas City	125
Wathanacharoen, Suchint	Kansas City	125
Watkins, Geo L	Rancho Santa Fe	138
Watson, Richard A	St. Joseph	030
Watson, Tom F	Springfield	082
Watson, Trevor F	Columbia	026
Watts, Byron E	Jefferson City	058
Watts, Jane M	Kansas City	125
Watts, Larry K	St. Joseph	030
Watts, Samuel M	Aurora	166
Wax, Martin B	St. Louis	190
Waxelman, Roger J	Ballwin	190
Waxman, Dan A	Kansas City	125
Waxman, Jane Z	Lenexa	125
Waxman, Joel E	Springfield	082
Waxman, Michael J	Kansas City	125
Wayne, Sherwyn J	St. Louis	190
*Weaver, Bruce E	Columbia	026
Weaver, Dana J	Columbia	026
Weaver, Mark E	Springfield	082
Weaver, Michael L	Kansas City	125
Webb, Harry E	Kansas City	125
Webb, James P	Springfield	082
*Webb, James J	Joplin	102

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*Doctor of osteopathy.

Webb, John M	Kansas City	050
Webb, Karen B	St. Louis	190
Webb, Paul B, Jr.	St. Louis	190
Webber, William B	St Louis	190
Weber, J. Russell	St. Louis	190
Weber, Thomas R	St. Louis	190
Weber-Bornstein, Nancy	Cape Girardeau	042
Wee, Geo C	Chesterfield	190
Weeks, Paul M	St Louis	190
Wehrman, Stephanie A	Chesterfield	190
Weide, Allan R	N Kansas City	050
Weiford, Edward C	Shawnee Mission	125
Weigand, Robert T	St. Joseph	030
Weiler, Thomas J	St. Louis	190
Weinand, Ernest E	St Joseph	030
Weinberger, Phillip C	Lexington	118
Weinstein, Chas L	Kansas City	125
Weinstein, David L	St. Louis	190
Weinstein, Stephen H	Columbia	026
Weir, Don C	St. Louis	190
Weir, Robt K	Kansas City	125
Weir, Royal A	Ballwin	190
Weis, Landy	St. Louis	190
Weis, Ronald R	Kansas City	125
Weise, Marc W	St. Louis	190
Weiss, Alan N	St Louis	190
Weiss, Howard	St Louis	190
Weiss, James M	Columbia	026
Weiss, James J	Jefferson City	058
***Weiss, Randy B**	Joplin	102
Weiss, Stuart	St Louis	190
Weldon, Virginia V	St. Louis	190
Welke, Gordon A	Poplar Bluff	034
Wells, Donald E	Atlantic Beach	125
Wells, Samuel A, Jr.	St. Louis	190
Welsh, Jon A	Overland Park	215
Welsh, Laurence C	St. Louis	190
Welsh, Thomas E, III	Mexico	014
Welter, Eugene S	Kansas City	125
Weltmer, John B, Jr.	St. Louis	190
Welton, Stephen T	Sikeston	202
Weltscheff, Christo A	Lincoln	086
Wempe, Geo R	Maryville	158
Wenneker, Alvin S	St Louis	190
Wenner, Herbert A	Shawnee Mission	125
Werner, Dean F	Kansas City	050
Werner, F. Scott	Kansas City	050
Werner, Franklin C	Liberty	050
Werner, Harold V	West Plains	206
Werner, William A	St. Louis	190
Werth, Joseph A	Jefferson City	058
***Wescott, Thomas P**	Holden	110
West, Harold D	Independence	125
West, James C, Jr.	Kansas City	125
West, Joseph W	St. Louis	190
Westblom, T. Ulf	St. Louis	002
Westcott, Bruce R	Cape Girardeau	042
Westerfeld, Roy A	St Charles	189
Westerman, Robt N	St Louis	190
Westfall, Susan H	Chesterfield	190
Westgate, Steven J	Columbia	026
Westhoff, David D	Jefferson City	058
Weston, Kenneth G	Columbia	026
Westrich, David J	Cape Girardeau	042
Westrup, Ellsworth A	Eureka	190
Wetzel, Gus S	Clinton	086
Wexler, Stephen A	St. Louis	190
Weyerich, Noel F	St Louis	190
Weygandt, Paul L, Jr.	West Plains	206
Weyman, Philip J	Chesterfield	190
Wheeler, Chas B	Kansas City	125
Wheeler, Paul D	Liberty	050
Wheeler, Robt L	Harrisonville	214
Whitaker, James H	Kansas City	125
White, Barry B	Puxico	034
White, Bruce I	St. Louis	190
White, Chas H	Shawnee Mission	125
White, Eugene F	Rolla	135
White, Harry H	Columbia	026
White, Heidi K	Brentwood	215
White, James S	Kansas City	125
White, Newton B	St Louis	190
White, R. Ned	Springfield	082
White, Russell D	Aurora	166
White, Stoughton F	Shawnee Mission	125
White, Wm E	Kansas City	125
Whitehead, Clay C	St. Joseph	030
Whitener, Miles C	St Louis	190
Whiteside, Leo A	Bridgeton	190
Whiting, Richard B	St. Louis	190
Whitlock, C. Courtney	Springfield	082
Whitman, Daniel S	Kansas City	125
Whitmore, J. Stewart	Washington	125
Whittaker, Chas K	Kansas City	125
Whittaker, Thomas J	Kansas City	215
Whitten, J S	Cape Girardeau	042
Whitten, M. Foster	Carthage	102
Whittenberger, Brock P	Cape Girardeau	042
Whittico, James M	St Louis	190
Wiant, James R	St Louis	190
Wible, Jerry C	Springfield	082
Wice, Martin B	St. Louis	190
Wick, Mark R	Fenton	002
Wiegand, Herbert C	St. Louis	190
Wiele, Kimberly N	St. Louis	190
Wienke, Eugene C	St. Louis	190
Wiens, Robert D	St. Louis	190
Wientzen, Arthur S	Kansas City	125
Wilbers, Raymond H	Mexico	014
Wilbois, Ronald P	St Louis	190
Wilcox, Dennis M	Leawood	125
Wilcox, Ruth E	Joplin	102
Wild, Alan P. K.	Chesterfield	190
Wilhelm, Warren F	Lake Ozark	125
Wilkins, Michael S	Kansas City	125
Wilkinson, Charles B	Kansas City	125
Wilkinson, David	St Louis	190
Wilkinson, Everett A	Prairie Village	125
Willcoxon, Robert L	Joplin	102
Williams, Carol F	St. Louis	190
Williams, Charlie B, Jr.	West Plains	206
Williams, Craig	Cape Girardeau	042
Williams, Fred	Columbia	026
Williams, George A	St. Louis	190
Williams, John M	Kansas City	050
Williams, John W, IV	Springfield	082
Williams, Joseph C	Shawnee Mission	125
Williams, Joseph	St.louis	190
Williams, Kathleen M	Kansas City	125
Williams, Paul A	Kansas City	125
Williams, Paul A	St. Louis	002
Williams, R. Jerome , Sr.	St. Louis	190
***Williams, Robert J**	St. Joseph	030
Williams, Robert D	Kansas City	050
Williams, Roland D	Kansas City	125
Williams, Roy J, Jr.	St. Louis	190
Williams, Starks J	Kansas City	125
Williams, Wendell N	St. Louis	190
Williamson, Geo L	Phoenix	050
Williamson, Mark B, Jr.	Kansas City	125
Williamson, Walter E	Bridgeport	190
Willman, Charles R	St. Joseph	030
Willman, Martin L	St Charles	189
Willman, Vallee L	St. Louis	190
Willoughby, Jean B	Kansas City	125
Willumsen, Henry C	St. Joseph	030
Wilson, Alice H	Neosho	102
Wilson, Chas F	Cape Girardeau	042
Wilson, Clifford C	Walnut Creek	125
Wilson, David E	Smithville	050
Wilson, Geo P	Columbia	026
Wilson, J. Mark	Springfield	082
***Wilson, James W**	Springfield	082
Wilson, Roy E	Springfield	082
Wilson, Timothy A	Smithville	050
Wilson, Vicki R	Kansas City	125
***Wilson, W. Timothy**	Springfield	082
Wilt, David A	Kansas City	125
Wilucki, Melvin R	St Louis	190
Wimmer, Warren J	Florissant	190

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*Doctor of osteopathy.

Windmiller, M. Eugene	Columbia	026
Winer, Herbert J	Kansas City	125
Winer, Michael H	St Louis	190
Winer, Nathaniel	Kansas City	125
Winkelman, Esther B	Kansas City	125
Winkelmeyer, William K	Columbia	026
Winn, Geo W	Boonville	026
Winnacker, John L	Columbia	026
Winsky, Arlen D	Springfield	082
Winter, Tyrus D	St Louis	190
Winters, Kathleen	St. Louis	190
Winton, Mark D	Jefferson City	058
Wipfler, Earl J	St. Charles	189
Wise, Geo W	Shawnee Mission	125
Wise, Morris F	Kansas City	125
Wissner, Seth E	St. Louis	190
Withrow, Donald	St. Louis	190
Withrow, John B	Kansas City	050
Witkop, Kimberly A	Kansas City	215
Witt, Clyde M	St. Louis	190
Witten, David M	Columbia	026
Wittgen, Catherine	St. Louis	215
Wittgen, Edward M	St. Louis	190
Wittler, Harry A	St. Louis	190
Wittmer, Marc R	Springfield	082
Wittmer, Saml C	Springfield	082
Woeltje, Keith F	Ballwin	215
Wogahn, Brent M	Raytown	215
Wolanski, Eugene G	St Joseph	030
Wolf, Jack W	Kansas City	125
Wolf, Marion L	Springfield	082
Wolfe, Edward M	St Louis	190
Wolfe, James B	Springfield	082
Wolfe, John E	Springfield	082
Wolfe, Oliver J	Ballwin	002
Wolff, Dolores P	St. Louis	190
Wolff, Gerald A	St Louis	190
Wolff, Harold D	St. Louis	190
Wolff, Ray J	St. Louis	190
Wolfgram, Edwin D	St Louis	190
Wolski, James R	Springfield	082
Woltjen, John A	Kansas City	125
Won, Russell	St. Louis	190
Wonder, Donald	Branson	208
Wong, George F, III	Springfield	082
Wood, David G	Overland Park	125
Wood, John A	Chesterfield	190
Wood, Thos O	Poplar Bluff	034
Woodbury, Julie R	Kansas City	215
Woods, Gerald M	Kansas City	125
Woods, John J, Jr.	St. Louis	190
Woods, Walton C	Kansas City	125
Woodward, Wm W	Holiday Island	125
Wool, Gerald	St Louis	190
Wooldridge, Wilfred E	Springfield	082
Woolery, William G	Sedalia	178
Woolsey, Joyce E	St. Louis	190
Wooten, Michael B	Springfield	082
Workman, Chas E	Mission	050
Workman, Geo M	Hermann	074
Worley, Charles A	Laurie	120
Worth, Eugene R	Columbia	026
Wortmann, Robt F	Shawnee Mission	125
Wotawa, Wm J	St Louis	190
Wright, Andy J	Springfield	082
Wright, Jeffrey M	St. Louis	190
Wright, R P	Shawnee Mission	125
Wright, Robert W, III	Kansas City	125
*Wright, Robert A	St. Louis	190
Wright, William P	St. Louis	190
Wu, Wm Q	Kansas City	125
Wuellner, David H	Sedalia	178
Wulfers, Michael C	Cape Girardeau	042
Wulff, Geo J	Miami	190
Wurm, Michael J	Maryville	158
Wurr, Dieter H	Arnold	190
Wurster, Jerry B	Kansas City	125
Wurster, Mark W	Kansas City	125
Wurster, W J	Kansas City	125
Wyatt, Ronald M	St. Louis	002
Wyrsch, Leo M	Springfield	082

Y

Yadav, Sanjay S	Kansas City	125
Yagan, Mark B	Overland Park	215
Yang, H. Kell	Columbia	026
Yang, John S	Ste. Genevieve	174
Yannakakis, John E	Florissant	190
Yanover, Robert A	St. Charles	190
Yanow, Mitchell	St. Louis	190
Yap, Mardonio J	Florissant	190
Yarwood, Robert L	Lake St. Louis	189
Yasin, Fazle M	St. Louis	190
Yates, Darrel W	St Louis	190
Yates, John M	Jefferson City	058
Yates, Karen	Cape Girardeau	042
Yazdi, Tom M	Crestwood	190
Yeast, John D	Kansas City	125
Yedlin, Jay H	Kansas City	125
Ylagan, Amando , Jr.	St. Louis	190
*Yocum, Russell S	Platte City	125
Yontz, David L	Clayton	190
Yoo, Chong-Sup	Festus	106
Yoon, Jin S	Chillicothe	078
Yoon, Kong-Woo	St. Louis	190
Yoselevsky, Robert	St. Louis	190
Yost, John G, JR	Kansas City	125
Youll, Donald V	Kansas City	125
Youmans, Ronald A	Kansas City	125
Young, James E	Shawnee Mission	125
*Young, Michael A	Jefferson City	058
Young, Patricia A	No Kansas City	050
Young, Paul H	St. Louis	190
Young, Robert A	Chesterfield	190
Young, Robt B	Rolla	135
Young, Thomas J	St Joseph	030
Young, Vernon L	St. Louis	190
Youngblood, James P	Kansas City	125
Younger, Anita C	Kansas City	190
Younger, Ernest	Kansas City	190
Yoxall, Kelly E	Kansas City	215
Yu, Mario K	Kansas City	125
Yuhas, John A	Joplin	102
Yuhas, Michael E	Joplin	102

Z

Zacharewicz, Lisa J	Kansas City	125
Zacharias, Kulangara P	Columbia	026
Zacharias, Sara	Columbia	026
Zachary, Paul E, Jr.	Lenexa	215
Zahn, Robt L	Springfield	082
Zanol, John M	Columbia	026
Zanol, Karen E	Columbia	215
Zarr, James S	Kansas City	125
Zehnder, Kenneth W	St. Louis	190
Zeigler, Jos M	St. Louis	190
Zekert, Horst	St. Louis	190
Zerr, Charles H	Independence	125
Zia, Rashid	Bridgeton	190
Ziegler, Robert E	St. Louis	190
Ziemianski, Matthew C	Kansas City	125
Zimmerman, Devin D	Grover	190
Zimmerman, Herbert B	St Louis	190
Zimmerman, Joe A	Kennett	070
Zink, Thomas K	St. Louis	190
Zinn, Marcia V	Kansas City	125
Zitsch, Robert P, III	Columbia	026
Zivnuska, Frederick R	St. Louis	190
Zoffuto, Anthony C	Cape Girardeau	042
Zoller, David D	Blue Springs	125
Zuerlein, Terrance J	Kansas City	125
Zukaitis, Mark G	Kansas City	125
Zukowski, Edward T	Chesterfield	190
Zurowski, Susan M	Columbia	026
Zylka, J. Michael	St. Louis	190

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*Doctor of osteopathy.

Codes for Self-Designation of Practice Specialties by Specialty

ADM	**Addiction Medicine**
ADL	Adolescent Medicine
AM	**Aerospace Medicine**
A	Allergy
AI	**Allergy & Immunology**
ALI	Allergy & Immunology/Diagnostic Laboratory Immunology
AN	**Anesthesiology**
CCA	Anesthesiology, Critical Care
APM	**Anesthesiology, Pain Management**
CD	Cardiovascular Disease
CCM	**Critical Care Medicine**
D	Dermatology
DMP	**Dermatopathology**
DDL	Dermatological Immunology/Diagnostic Laboratory Immunology
DIA	**Diabetes**
EM	Emergency Medicine
END	**Endocrinology**
FPS	Facial Plastic Surgery, Otolaryngology
FP	**Family Practice**
FPG	Family Practice, Geriatric Medicine
FSM	**Family Practice, Sports Medicine**
GE	Gastroenterology
GP	**General Practice**
GO	Gynecological Oncology
GYN	**Gynecology**
HEM	Hematology
IG	**Immunology**
ID	Infectious Diseases
IM	**Internal Medicine**
ICE	Internal Medicine, Cardiac Electrophysiology
ILI	**Internal Medicine/Diagnostic Laboratory Immunology**
IMG	Internal Medicine, Geriatrics
LM	**Legal Medicine**
MFM	Maternal & Fetal Medicine
MM	**Medical Microbiology**
NPM	Neonatal-Perinatal Medicine
NCC	**Neurological Surgery, Critical Care**
NEP	Nephrology
N	**Neurology**
CHN	Neurology, Child
CN	**Neurology, Clinical Neurophysiology**
NSP	Neurology, Pediatric Surgery
NM	**Nuclear Medicine**
NR	Nuclear Radiology
NTR	**Nutrition**
OBS	Obstetrics
OBG	**Obstetrics & Gynecology**
OCC	Obstetrics & Gynecology, Critical Care Medicine
OM	**Occupational Medicine**
ON	Oncology, Medical
OPH	**Ophthalmology**
OAR	Orthopedic Surgery, Adult Reconstructive Orthopedics
HSO	**Orthopedic Surgery, Hand Surgery**
OMO	Orthopedic Surgery, Musculoskeletal Oncology
OP	**Orthopedic Surgery, Pediatric Orthopedics**
OSM	Orthopedic Surgery, Sports Medicine
OSS	**Orthopedic Surgery, Spine Surgery**
OTR	Orthopedic Surgery, Trauma
OTO	**Otolaryngology**
OT	Otology
ATP	**Pathology, Anatomic**
PTH	Pathology, Anatomic/Clinical
BBK	**Pathology, Blood Banking**
PCH	Pathology, Chemical
CLP	**Pathology, Clinical**
PCP	Pathology, Cytopathology
FOP	**Pathology, Forensic**
HMP	Pathology, Hematology
PIP	**Pathology, Immunopathology**
NP	Pathology, Neuropathology
PP	**Pathology, Pediatric Pathology**
RIP	Pathology, Radioisotopic
PD	**Pediatrics**
PDA	Pediatric Allergy
PDC	**Pediatric Cardiology**
CCP	Pediatric Critical Care
PLI	**Pediatric/Diagnostic Laboratory Immunology**
PEM	Pediatric Emergency Medicine
PDE	**Pediatric Endocrinology**
PG	Pediatric Gastroenterology
PHO	**Pediatric Hematology-Oncology**
PN	Pediatric Nephrology
PDP	**Pediatric Pulmonology**
PA	Pharmacology, Clinical
PM	**Physical Medicine & Rehabilitation**
HSP	Plastic Surgery, Hand Surgery
GPM	**Preventive Medicine, General**
P	Psychiatry
CHP	**Psychiatry, Child**
PYG	Psychiatry, Geriatric
PYA	**Psychoanalysis**
PH	Public Health
PUD	**Pulmonary Disease**
RO	Radiation Oncology
R	**Radiology**
DR	Radiology, Diagnostic
PDR	**Radiology, Pediatric**
TR	Radiology, therapeutic
VIR	**Radiology, Vascular and Interventional**
REM	Reproductive Endocrinology
RHU	**Rheumatology**
AS	Surgery, Abdominal
CDS	**Surgery, Cardiovascular**
CRS	Surgery, Colon & Rectal
CCS	**Surgery, Critical Care**
GS	Surgery, General
HNS	**Surgery, Head & Neck**
NS	Surgery, Neurological
ORS	**Surgery, Orthopedic**
PDS	Surgery, Pediatric
PS	**Surgery, Plastic**
TS	Surgery, Thoracic
TRS	**Surgery, Traumatic**
U	Surgery, Urological
VS	**Surgery, Vascular**
UM	Undersea Medicine

In addition to the above, the following specialty designations are also used:

OS	**Other (i.e. a specialty other than those appearing above)**
US	Unspecified

Membership Roster by Primary Specialties

A-ALLERGY

Bolinske, Robt E St Louis
Caldwell, Joseph L Springfield
Chapman, Jean A Cape Girardeau
Christ, Martin H St Joseph
Cooper, Barry J St. Louis
Critchlow, Michael E Columbia
Dankner, Rand E Chesterfield
Kahn, Marvin Kansas City
Korenblat, Phillip E St. Louis
Maxson, Theodore R Warrensburg
Miles, Wayne B Springfield
Nguyen, Helen T St. Joseph
Olive, Geo C Neosho
***Sacha, Robert F** Cape Girardeau
Sportsman, Weldon L Kansas City
Straub, David L Joplin
Stricker, William E Rolla
Strunk, Robert C St. Louis
Thiel, J. Allen St Louis
Vandewalker, Mark L Rolla
Wood, John A Chesterfield
Youll, Donald V Kansas City

AN-ANESTHESIOLOGY

Abada, Roland St. Louis
Adams, Riley R Cape Girardeau
Ahmad, Bashir Pacific
Ali, Mohammed E Independence
Almuttar, Wasif F Maryville
Axness, Mark E Springfield
Ayata, Sedat M St Louis
Azzam, Farid J St. Louis
***Baade, Norman F** St. Joseph
Bagby, Jack M, Jr Springfield
Bailiff, Robert Springfield
Bashford, Eileen A No Kansas City
Batan-Co, Ruby L Chesterfield
Beare, Lucia V St. Louis
Behbahani, Parviz M Bridgeton
Bell, Stephen St. Louis
Bernard, Lisa Leawood
Binda, Robert E Kansas City
Blackwell, Charles R St. Louis
Bluestone, Kenneth I Kansas City
Blum, Carol A Excelsior Spgs
Blum, Philip C Kansas City
Bode, Eugene T Kansas City
Bopp, Sandra L Brentwood
Borup, Jerrell L Springfield
Bowenschulte, Bradley A Springfield
Bowers, Gregory R Sikeston
Bowser, Robert L Independence
Braunschweig, Ralph Columbia
Bredemann, Jeffrey A Kansas City
Brian, Wm J Springfield
Brigden, Robert B Joplin
Brown, Freeman F, III Ballwin
Brown, Michael S Columbia
Brummett, Richard R, Jr. St. Joseph
Bruns, Kenneth St. Louis
Bult, Mark J Springfield
***Burris, Charles W** Ballwin
Butterfield, Mari Anne Lee's Summit
Casement, Brian A Kansas City
Chang, Chil K Columbia
Charapata, Steven G Kansas City
Chesney, George W Joplin
Clemens, Robert M Sedalia
Cobb, Milton L St Louis
Cohen, Harry B Mexico
Cohn, Steven G Kansas City
Comens, Ruth C St Louis
Cook, James R Springfield
Couper, Nicholas B Columbia
Cox, Thomas E Cape Girardeau
Crawford, Oral B Springfield
Crighton, M. Nanette Springfield
Criscione, James S St. Louis
Cunningham, Milamari A Columbia
Daily, James M Springfield
Danner, Shavonne L Kansas City
***Davis, Larry E** Kansas City
***Delaney, Adrain J, Jr.** Kansas City
DeBoard, James W St. Louis
Dillard, Sandy R Joplin
Doerhoff, Adelia L Jefferson City
Dolan, Patrick H St. Louis
Douglass, Eric J Gladstone
Duerksen, Joseph J Kansas City
Eggers, George W, Jr. Columbia
Eldin, Ali St. Louis
Ellis, Ronald L Springfield
Essmyer, Joseph K Cape Girardeau
Esther, John W Springfield
Fabian, Leonard W St Louis
Faszholz, Mark S St. Louis
Fehlman, Bernard F St. Louis
Ferrari, Herbert A St. Louis
Fibuch, Eugene E Kansas City
***Fisher, Robert B** Columbia
Flores, Jhonson E St. Louis
Foote, Daniel D Springfield
Forand, Joseph M St. Louis
***Frederick, Mark R** Jefferson City
Friedman, Michael J Kansas City
Friend, T. Gregory Kansas City
Fromme, Glenn A Springfield
Gholkar, Vijay R Kansas City
Gibbons, James J St. Louis
***Gibbons, Jerry L** Baldwin
Gibbons, Robert T, Jr. Overland Park
Gibson, William P Chesterfield
Gile, Robert J Cape Girardeau
Glenski, James A Kansas City
Glickman, Andrew S New York
Gordon, Bruce J Columbia
Griffin, Donald R Kansas City
Gupta, Nilakshi Columbia
Gurba, Carol L Kansas City
Guy, Cynthia S St. Louis
Hagen, Douglas W Kansas City
Hari, Magaral S Joplin
Herdoiza, Alfonso W Overland Park
Hervey, Wm H Kansas City
Hinds, R. David Columbia
Hirshberg, Gary E St. Louis
Hoech, Geo P, Jr. Kansas City
Hogue, Charles W, Jr. Clayton
Holloway, Robert B St. Louis
Holtmeier, Douglas L Festus
Hudson, Randall B Kansas City
Huff, Kalaichelvi R Joplin
Hull, Timothy A Kansas City
Ikeda, Shigemasa St. Louis
Iwane, Akira Chesterfield
Jaax, Jeffrey D Kansas City
Janeczko, Gregory F Springfield
Jenkins, James J St Louis
Johans, Thomas G St. Louis
Johnson, Garry A Manchester
Jones, Gale O Kansas City
Jones, Robin R Columbia
Kappesser, Roland C St Louis
Keller, Barbara P Columbia
Kelly, Joseph G No. Kansas City
Kenney, John D, III Kansas City
***Kesseler, Randall G** Springfield
Khoury, Cecile S Leawood
Kim, William W St. Louis
Kimble, Harvey S Kansas City
King, Robert W Rolla
Kiyanclar, M. Emin St. Louis
Krechel, Susan W Columbia
Krug, Paul E Kansas City
Kulkarni, Nandini S St. Louis
Lampert, Benjamin A Springfield
***Landers, Milton H** St. Joseph
Landrum, Alice L Columbia
Laposky, Lynda L Chesterfield
Lappas, Demetrios G St. Louis
Laughlin, Thomas P Kansas City
Lee, Leander K St. Louis

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*Doctor of osteopathy.

Lerner, Bruce Independence
Lobdell, Creig M Springfield
Loesch, J. John Joplin
Lonergan, James H Kansas City
Ludwikosky, Mikel A Lee's Summit
Lynch, Gerald C Kansas City
Lytle, Michael F Mission Hills
Macler, Henry H, Jr. St. Louis
Maddipati, Sreedezi St. Louis
Madlang, Rudy G Columbia
Mallow, James E Kansas City
Matson, Jeffrey A Kansas City
Matthews, J. Mark Kansas City
Mayuga, Edgardo G St. Louis
McCord, E. Scott Columbia
McCray, Stephen A N. Kansas City
McDonald, Michael G Joplin
McIntosh, Donald E Kansas City
***McLaughlin, Dan A** St. Joseph
McNitt, Jay D Kansas City
Mestad, Peter H Kansas City
***Michael, Roy A** Jefferson City
Miller, Robert N St. Louis
***Miller, Robin C** Ballwin
Moore, Richard E Cape Girardeau
Morgan, Richard L Kansas City
***Morley, Ronald F** Jefferson City
Morrison, Robert R Kansas City
Murray, Eric Jefferson City
Muzaffaruddin, Mohammed St. Louis
Nelson, Richard E Kansas City
Nielsen, Carl H St. Louis
Oakley, Margaret M St Louis
Opper, Susan E Kansas City
Owens, William D St Louis
Parker, Craig A Kansas City
Parker, Kim E Kansas City
Patel, Bipin T St. Joseph
Pavelonis, Joel D Kansas City
Petersen, Larry D Springfield
Piontek, James F Liberty
Politi, Gregory B Kansas City
Porter, Michael J Kansas City
Porter, Susan S Kansas City
Potts, Fred E, III Springfield
Powers, Catherine A Leawood
Pryor, Ira Joe Joplin
Ramirez-Inawat, Rebecca C Chesterfield
***Ray, Terry L** Columbia
Reimer, Donald R Cape Girardeau
Rodrigo, Bernardo R St. Louis
Rofail, Amin A Shawnee Mission
Romkema, George E St. Louis
Roth, Alfred D Mission
***Russell, Robert B** Cape Girardeau
Sabatino, Anthony Kansas City
Schane, Catherine L Springfield
Schneider, Alan R St. Louis
Schneider, J. Michael Springfield
Schneider, Sally L St. Louis
Schranck, Chas R, Sr. St. Louis
Schroeder, Gerard R Cape Girardeau
Schuessler, Edward C St. Louis
Schweiss, John F St. Louis
Shaw, David A Rolla
Shelley, William C Kansas City
***Shipman, Wade M** Springfield
Simon, Gracita S Smithville
Slimack, Joseph P St.Louis
***Smith, Toni R** Kirksville
Smolik, Martin J, Jr. Joplin
Southwick, Christopher L Columbia
Spade, Diana J Springfield
Steele, Jeffrey S Cape Girardeau
Stoops, Stephen L Kansas City
Stromberg, Eric D Kansas City
***Suthoff, Jim** Joplin
Tate, Kara L Kansas City
***Tewis, Huey D** Cape Girardeau
Thomas, James J Kansas City
Thompson, David E Independence
Tiojanco, Milagros E Kansas City
Tomlinson, David L Kansas City
Towle, Daniel J Kansas City
Tuohy, Gerald F Kansas City
Turner, Marc A Kansas City
Venneman, Charles R Kansas City
***Vialle, Gene M** Kansas City
Villafuerte, Nila A Chesterfield
Vogel, Arthur P Shawnee Mission
Wagner, Paul J Greenwood
Waring, J. Michael Kansas City
Watson, Tom F Springfield
***Weaver, Bruce E** Columbia
Weaver, Mark E Springfield
***Webb, James J** Joplin
Westcott, Bruce R Cape Girardeau
Wolfe, Oliver J Ballwin
Wolff, Dolores P St. Louis
Worth, Eugene R Columbia
Wright, Robert W, III Kansas City
Yedlin, Jay H Kansas City
Young, Patricia A No Kansas City
Zinn, Marcia V Kansas City
Zukaitis, Mark G Kansas City

CD-CARDIOVASCULAR DISEASE

Ahuja, Suraj P Kansas City
Akin, C. David Independence
Ashley, Lillard G, Jr. Kansas City
Aykent, Yavuz St. Louis
Bagwe, Ranjit M St Charles
Bai, Samuel S Festus
Barr, W. Kent Kansas City
Beauchamp, Gary D Kansas City
Bell, Hubert H Kansas City
Best, John F Springfield
Biel, Stanley I Bridgeton
Bloom, Stephen A Kansas City
Bogart, Douglas B Kansas City
Bowman, W. Kirk Cape Girardeau
Bresnahan, Dennis R Kansas City
Callicoat, Paul E, Jr. Joplin
Carr, Phillip W Springfield
Catanzaro, Frank J, Sr. St Louis
Ceaser, James H Springfield
Chapman, James B Cape Girardeau
Charles, Francois St Louis
Chun, Duck S St. Louis
Conn, Robert D Kansas City
Cooper, C Wesley Springfield
Corcoran, Francis H Joplin
Cox, John M Joplin
Csaki, Bela Independence
Cupp, Gerald V Columbia
Detje, Robert L West Plains
Earnest, James B Kansas City
Fagan, Leonard F, Jr. St. Louis
Farrar, Michael W Kansas City
Freeman, James A Columbia
Freiman, Paul C Springfield
Gentsch, Kenneth W St. Louis
Ghosh, Nellie St. Louis
Glueck, Robert M Kansas City
Good, Thomas H Kansas City
Gowda, Siddhesh Chesterfield
Graham, Joseph E St. Louis
Gura, George M, JR. Kansas City
Hamilton, William P St. Louis
Harbrecht, James J Kansas City
Hartzler, Geoffrey O Kansas City
Haycraft, Gordon L Cape Girardeau
Hedge, S. Roy Kansas City
Henry, Clarke L, Jr Kansas City
Herman, Robert L Kansas City
Hills, Joe E Springfield
Hindupur, Mohan R St. Joseph
Jackson, Jay A Kansas City
Johnson, Warren L, JR Kansas City
Kennett, Jerry D Columbia
Kindred, Lynn H Kansas City
Kroetz, Frank W Sikeston
Laughlin, Edward J Independence
LaFoe, William K Cape Girardeau
Lee, Gerald B Kansas City
Lee, Jung H Crystal City
Levi, Bernard Kansas City
McCallister, Ben D Kansas City
McConahay, David R Kansas City
McDermott Timothy J Cape Girardeau
Meyer, Randall E Jefferson City
Miller, John T Kansas City
Mizell, Myron W Springfield
Montgomery, Michael A Kansas City
Moore, Thomas B Joplin
Mukharji, Jhulan Kansas City
Murphy, J. Peter , Jr. St. Louis
Myears, Donald W Springfield
Nelson, J. Roger St Louis
Oliver, G. Charles St. Louis
Ostrow, Louis B Cape Girardeau
Parker, Brent M Columbia

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*Doctor of osteopathy.

CDS-CARDIOVASCULAR SURGERY

Pinckley, James N Springfield
Politte, Lenard L Columbia
Ritter, William S Kansas City
Roselman, Michael J Springfield
Ruff, Paul G Springfield
Rutherford, Barry D Kansas City
Sabapathy, Shawn Joplin
Sanders, Jack S Jefferson City
Scharf, Daniel Kansas City
See, W. Mike Columbia
Shafer, Kenneth E West Plains
Shimshak, Thomas M Kansas City
Spadaro, James J St. Louis
Spitler, Allen L Cape Girardeau
Spurny, Otto M Kansas City
Steinhaus, David M Kansas City
Stickley, Louis P St Louis
Sweeney, Michael J Kansas City
Talbert, Clifford R Cape Girardeau
Van Osdol, Kelvin D Springfield
Vournas, George C Bridgeton
Weiss, Alan N St Louis
Wiens, Robert D St. Louis

CDS-CARDIOVASCULAR SURGERY

Borkon, A. Michael Kansas City
Bryant, Lester R Columbia
Carter, James S Columbia
Crouch, John A Columbia
Curtis, Jack J Columbia
Ferguson, Thomas B St Louis
Foley, Jonathon K Cape Girardeau
Garrett, Ted E St. Louis
Hannah, Hamner , III Kansas City
Kase, James B, Jr. Kansas City
Long, John W Columbia
Mangalat, Narayanan K Joplin
Marbarger, John P, Jr. St. Louis
McCroskey, Brian L Kansas City
Morrison, Stephen K Springfield
Pennington, D. Glenn St. Louis
Roper, Charles L St Louis
Rosenbloom, Michael St. Louis
Walls, Joseph T Columbia
Wareing, Thomas H St. Louis

CHN-CHILD NEUROLOGY

Ali, Syed S Granite City
Baska, Richard E Kansas City
Dodge, Philip R St Louis
Francisco, Clarence B Kansas City
Prensky, Arthur L St Louis

CHP-CHILD PSYCHIATRY

Alfie, Salomon Shawnee Mission
Buchanan, Barbara N Kansas City
Callahan, Jos D St Louis
Childs, Donna S Kansas City
Churchill, Stephen W Kansas City
***Conrace, Joseph E** Joplin
Edwards, James E St. Louis
Figueroa, Edduyn Florissant
French, M. Devonne Lee's Summit
Huk, Stephen G N. Kansas City
Husain, S. Arshad Columbia
Inniss, Rosalyn E Kansas City
Ketterman, Grace H Kansas City
Lorenzo, Edilberto B Kansas City
Moore, Harry G, Jr. St. Louis
Perll, Rita D Kansas City
Pfeffer-Hurwitz, Judith Overland Park
Poonawala, Huseni E Kansas City
Quiason, Emmeline P Independence
Rankin, Diane St. Louis
Raza, Syed A Belleville
Rizzo, Adolfo E St. Louis
Stanley, John H Kansas City
Sumer, Emel A Bridgeton

CLP-CLINICAL PATHOLOGY

Coffin, Cheryl M St. Louis
Druet, Robert L Springfield
Dunphy, Cherie H St. Louis
Haake, Gregory K Springfield
Meyer, John S Chesterfield
Paez, Mauro A St. Louis
Poger, Marshall E St. Louis
Posey, Douglas H, Jr. St. Joseph
Raborar, Arteso C Springfield
Wienke, Eugene C St. Louis
Withrow, Donald St. Louis

CRS-COLON & RECTAL SURGERY

Campbell, John G Kansas City
Conner, W. Edwin Kansas City
Fleshman, James W St. Louis
Gose, Don F Springfield
Graham, Bruce D Kansas City
Heryer, John W Kansas City
Kodner, Ira J St Louis
Robbins, Philip L St Louis
Vernava, Anthony M, III St. Louis

D-DERMATOLOGY

Ailor, Susan K Columbia
Albert, I. Renee Overland
Anderson, Daphne W Springfield
Anderson, Frank K St. Charles
Anderson, Lynn A Springfield
Anderson, Philip C Columbia
Aronberg, Jerome M St Louis
Ashby, Jennifer D No Kansas City
Bauschard, Frederick D St. Louis
Brown, Henry (hal) S Cape Girardeau
Burkhart, Edward F St. Louis
Creech, Fred T Columbia
Dempsey, Kenneth J Sikeston
DeSpain, John D Columbia
Dilworth, Jacquelyn B St. Louis
Dyer, Gary A St Joseph
Eisen, Arthur Z St. Louis
Foote, Jerry E Columbia
Gentry, Michael A Springfield
Griffin, Darrell L Farmington
Gunn, Victoria Jefferson City
Gunnoe, Robert E Kansas City
Hall, John C Kansas City
Harner, Casper G St Joseph
Higgins, Ronald A Kansas City
Hilton, Paul E Joplin
Hironimus, John E St Louis
Hookerman, Bruce J Bridgeton
Hruza, George J St. Louis
Huewe, Douglas A Springfield
Johnson, Dallas A Overland Park
Key, James S Springfield
Lane, Daniel K St. Louis
Levenson, Ina Poplar Bluff
Lorenc, Ernest Springfield
Lund, Robert H, Jr. Chesterfield
Lynch, Thos W Springfield
Major, Troy E Springfield
Marrs, David B St. Charles
McCadden, Michael E St. Louis
Medler, P. Louis St Louis
Melia, B J, Jr. Kansas City
Miller, Charles W St. Louis
Morrow, N. Eugene Springfield
Muelleman, Peter J Independence
Oleson, Gale B Blue Springs
Palmer, Stephen M St. Louis
Payne, David E Columbia
Portnoff, Lee S St. Louis
Powell, John A St Louis
Reese, Lester T St. Louis
Roller, James A Columbia
Sanchez, Guadalupe St. Peters
Schoentag, John S St. Louis
Schoonmaker, Gene Springfield
***Schwarze, Robert F** Florissant
Scott, Jamie A Springfield
Simmons, Jess S Joplin
Stoecker, William V Rolla
Swinfard, Ronald W Columbia
Thomas, F. Anthony Kansas City
Tiefenbrunn, Sharon F St. Louis
Tucker, Dolores R Chesterfield
Uhlemann, John H St Charles
Vitale, Stephen J Ballwin
Vollmar, Lewis C, Jr. St Louis
***Walker, David Brooks** Bridgeton
Walsh, Richard J St. Joseph
Werth, Joseph A Jefferson City
Wolfe, Edward M St Louis
Ziegler, Robert E St. Louis

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*Doctor of osteopathy.

Zurowski, Susan M Columbia

DR–DIAGNOSTIC RADIOLOGY

Amato, Maryellen St. Louis
Amini, Jafar Kansas City
Anthony, James P Kansas City
Applewhite, Thomas A St. Louis
Balfe, Dennis M St. Louis
Bartlett, John E Springfield
Beal, Catherine E St. Louis
Belshe, Sidney B Jefferson City
Blackwell, Chas W Columbia
Brent, Lanny R, Jr Springfield
Brown, Mike J Cape Girardeau
Carlton, Lynn N Springfield
Chow, Susanne M Overland Park
Churchill, Robert J Columbia
Claycomb, Gerald K Chesterfield
Cloogman, Howard M Overland Park
Cooper, Barry R N Kansas City
Crabtree, Jay B Bolivar
Cronemeyer, Richard L Leawood
Cubillo, Enrique Chesterfield
Cupples, Tommy E Cape Girardeau
Cusumano, Joseph St. Louis
Cyriac, George K Mexico
Davis, Gene L St Louis
Davis, W. Bob Overland Park
Dell, Robert V Hannibal
Dever, Robert L Joplin
Dierberg, Dale F Chesterfield
Dixon, Geo D Kansas City
Edelman, Alan H St. Louis
Ernst, Edwin C, III St. Louis
Fisher, James K Kansas City
FitzSimmons, James G Kansas City
Francis, Roger A Osage Beach
Furlong, Lawrence D Kansas City
Garrotto, Lewis J Columbia
Gehm, Louis E Butler
Gennaoui, Jad M St. Louis
Geurkink, John W Joplin
Gilula, Louis A St Louis
Glazer, Harvey S St. Louis
Goetz, Joseph J Overland Park
Goodhope, Karen F St. Louis
Graviss, Edward R St. Louis
Greditzer, Harry G St. Louis
Gresick, Robert J, Jr. St. Louis
Hammerman, Albert M St. Louis
Hammerman, Harley J St. Louis
Hartman, Rodney C Sedalia
Hazuka, David F Shawnee Mission
Hinson, Gary W Prairie Village
Hoffman, Mark J St. Louis
Hooper, Anthony C Ballwin
Hutchinson, William B St Louis
Idstrom, Mark E Kansas City
Jacob, Kenneth M Kansas City
Jones, Maynard C, Jr. Kansas City
Jones, Paul S Joplin
Jost, R. Gilbert St. Louis,
Junker, James A St. Louis
Kelling, E. Collyer Springfield
Koontz, Kenneth L Kansas City
Lee, H. T. Columbia
Levine, Richard S St. Louis
Levitt, Robert G St. Louis
Link, Alexander J St Louis
MacDonald, Robin R Kansas City
MacDonald, Robt R, Jr. St Louis
Mayes, Ben R St. Louis
McClennan, Bruce L St. Louis
Melson, G. Leland St Louis
Merkle, John A St. Louis
Middleton, Mary A St. Louis
Mirowitz, Scott A Creve Coeur
Moore, Michael T Nevada
Moran, Christopher J St. Louis
Morgan, John L Springfield
Murphy, Wm A, Jr. St Louis
Nelson, David E Springfield
O'Toole, Patrick M Kansas City
Olson, Robert J Springfield
Omell, Gary H St. Louis
Orsay, Paul K St. Louis
Perkins, David E Chesterfield
Phillips, Stephen W Columbia
Pohl, David L St. Louis
Pottenger, L. Kenneth Joplin
Price, Hilton I St. Louis
***Radinsky, Stephen** St. Louis
Sabahi, Houman St. Joseph
Sadhu, Vijay K Columbia
Sanders, Harold L Columbia
Sauer, James M Springfield
Scearce, Robert L Jefferson City
Scheible, Robert F St Louis
Schwegler, Robert G Shawnee Mission
Shaplin, Alfred D Ballwin
Smid, Anne A Springfield
Smith, Emily L St Louis
Sobky, George H Louisiana
Soha, Joseph J, Jr. Columbia
Speckman, Jerry M Kansas City
Stephenson, Robert E Overland Park
Stevens, Edward M St. Joseph
Stoecker, Willeford J Cape Girardeau
Sullivan, Dan T Springfield
Sullivan, John A Springfield
Swaney, Charles M Columbia
Sweeney, Thos P Springfield
Tarneja, Kailash C West Plains
Thalblum, Harvey Kansas City
Thomasson, Jeffrey L St. Louis
Tobler, Jerry St. Louis
Trotta, Philip C St. Louis
Vesely, Thomas M St. Louis
Waddell, Thomas H Kansas City
Warsinski, Ivy M Maryville
Weis, Ronald R Kansas City
Wilcox, Dennis M Leawood
Wilson, J. Mark Springfield
Wolski, James R Springfield
Wood, David G Overland Park
Yates, Darrel W St Louis

EM–EMERGENCY MEDICINE

Bell, Malinda H Shawnee Mission
Blackburn, Michael D Columbia
Blaine, James R Springfield
Bonney, Saml C Washington
Carter, Gary L No Kansas City
Collier, Robert E N. Kansas City
Conner, Patrick T Springfield
Cordover, Mitchell B St. Louis
Criscione, James R, Jr. St. Louis
Crist, Roderic C Cape Girardeau
***Daniels, Edna M** Cape Girardeau
Dunlap, Michael D St. Joseph
Heim, Mary L Kansas City
Hicks, Robb R, IV Cape Girardeau
Hierholzer, Rebecca S No. Kansas City
Holbrook, C. R. , III Kansas City
***Jibben, Bobby J** Sikeston
Jotte, Randall S Kirkwood
Keesal, Dennis St. Charles
Kensel, Robert S Springfield
Kolda, Michael A Cape Girardeau
Labayen, Ricardo A Overland Park
***Landers, Gary A** N Kansas City
Leese, Philip T Lenexa
Lombardo, Richard J Springfield
Lorei, John M Parkville
Maranan, Diosdado L Arnold
McIntosh, Douglas A Cape Girardeau
McVey, Pamela S Kansas City
Mire, Louis E Springfield
Mobley, Gilbert L Springfield
Montgomery, John H, III Joplin
Moranville, Benedict A St. Joseph
Nierling, Dean A Columbia
Pancoast, Charles H Cape Girardeau
Patel, Raman J St. Joseph
Prickett, David C, Jr Kearney
***Pyron, Jimmy W** Joplin
Quick, Gary Chesterfield
Robinson, William A Kansas City
Russell, Steven L Liberty
Scarborough, Betty F Shawnee Mission
Scarborough, Mark R Kansas City
Schneider, Douglas A Lee's Summit
Spurgeon, Stephen St. Louis
Steele, Mark T Kansas City
Stoliar, Bruce St. Louis
Sullivan, Christine Overland Park
Szewczyk, Michael J Columbia
***Tedrick, Phillip D** Cape Girardeau
Waeckerle, Joseph F Kansas City
Weaver, Michael L Kansas City

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*Doctor of osteopathy.

Weber-Bornstein, Nancy Cape Girardeau

END-ENDOCRINOLOGY

Duda, Ralph J, Jr. Springfield
Hamburg, Mitchell S Kansas City
Henson, Bruce E Kansas City
James, Ronald C Columbia
Koppers, Lawrence E Kansas City
Kryshak, Edward J Springfield
Quick, William W Kansas City
Skor, Donald A St. Louis
Sneid, David S Kansas City
Sweet, Robert A Springfield

FPS-FACIAL PLASTIC SURGERY, OTOLARYNGOLOGY

Bart, Gerald N St. Louis
Cortez, Edwin A Kansas City
Copeland, Jeffrey G St. Charles
DeLeeuw, Karel A Springfield
Jernstrom, Vance R Kansas City
Petrie, Roy H St. Louis
Silverberg, Bruce St. Louis
Tanner, John P Kansas City
Thomas, J. Regan St. Louis

FP-FAMILY PRACTICE

Abu Dalu, Ziad St. Louis
Ahmad, Aqeeb St. Louis
Albers, Janet R Springfield
Allan, James E Jefferson City
Allcorn, Donald K Lincoln
Alonso, J. Mario , Jr. St Louis
Anglo, Luis B St Louis
Asaro, Phillip V St. Louis
***Asher, Kennett D** Jackson
Askew, John H Sikeston
Atkinson, Lance D Springfield
Auner, J. David Ironton
Ayres, Willa J Kansas City
Baker, Carl N St. Louis
Baker, Donald L Union
Barbe, David O Mountain Grove
Bareis, Robt J Marshfield
Bass, James J Rolla
Belden, Jeffery L Columbia
Bennett, John E Jefferson City
Berner, Carol T Springfield
Bernhardt, Gary D Overland Park
Binz, Donald E St. Charles
Bird, Jonathon M Farmington
Boatright, Kevin Farmington
Bodenhausen, Gary E Blue Springs
Bollier, Rene P Overland Park
Bowles, Richard P Liberty
Boydston, Catherine O Odessa
Boydston, Wyatt W Odessa
Bradley, J. Douglas St. Joseph
Bradshaw, Wm D Kansas City
Brody, Arnold G St. Louis
Brookreson, Alton D Poplar Bluff
Brown, Merlin D St. Joseph
Bruno, Ellen L Columbia
Brunworth, David Washington
Buffaloe, Robert N Jefferson City
Buie, Steven E Kansas City
Burcham, Tom R Farmington
Byrum, Fritz A Ballwin
Cady, Roger K Springfield
Caldwell, Fred Poplar Bluff
***Cantor, Sol F** St. Louis
Carr, George W Jefferson City
Carranza, Mauro J St. Louis
Caster, Philip W Lebanon
Catron, David O Cape Girardeau
Chaffin, Jerald D Branson
Charles, Nallathambi Festus
Chastain, Chas W Flat River
Chen, Alan J Dexter
Collison, R Michael Springfield
Colter, Kim D Washington
Colwill, Jack M Columbia
Comfort, Geo D Mexico
Conde, Gary A Joplin
Cooper, Chas W, II Jefferson City
Cooper, Thomas J Fulton
Covert, Richard A Ballwin
Crane, John L Lee's Summit
Cravens, William P Fulton
Crespo, Horacio T Warrenton
Crespo, Remedios R Warrenton
Crist, Charles L Cape Girardeau
Dang, Robert C Pleasant Hill
Davis, Carl S Lee's Summit
Davis, Ernest E St. Louis
Dean, Walter E Maryville
Dempsey, Herbert A Lee's Summit
***Dempsey, Herbert E** Lee's Summit
Devabhaktuni, Rama Devi Manchester
DeLine, Jim Macon
Dierker, Harry D Columbia
Dimayuga, Nestor G Mansfield
Dixon, Druery J West Plains
Domke, Henry F New Bloomfield
Donnell, Harold E De Soto
Donnell, William S, Jr Bolivar
Dorsch, Stephen E Independence
Downey, Jon P Cape Girardeau
Drabinowicz, Sallie E Springfield
Dunshee, Robt E Maryville
Durnell, Monaford D Kansas City
DuMontier, Alan J Chesterfield
DuMontier, Edward H Farmington
Dyer, Curtis W Warrensburg
Ekern, H. Peter Mexico
Elcock-Skimming, Devera M Ballwin
Elliott, Wendell H Poplar Bluff
Engelken, Michael K Mound City
Fakhoury, Donald A Kansas City
Farley, W. Joe Springfield
Farrell, Sammy L Washington
Fletes, James W St Louis
Fowler, Marvin L West Plains
Frazier, Robt L Sikeston
Gandlmayr, Jack M St Louis
Garrett, Elizabeth A Columbia
Gentry, Jim Springfield
Gilbirds, William M, II Kansas City
Glover, David Warrensburg
Godar, Sharon A Chesterfield
Goddard, Jerry L Cape Girardeau
Goff, John E Joplin
Good, Michael W Springfield
Graden, William R Springfield
***Graves, Karladine E** Kansas City
Grechus, John J Farmington
Green, Wm R St Louis
Greenlund, Nelson C Nevada
Griffith, S Kent Cape Girardeau
Grisham, Thomas D Washington
Groce, Geo D Fulton
Hall, David W Springfield
Hall, Terry E Bethany
Halverson, Larry W Springfield
Hamid, Rashid S Brunswick
***Hancock, Thomas J** Jefferson City
Hardy, Stanton L Desloge
Harr, Patrick B Maryville
Harris, Louis B Bolivar
Hastings, Mary V Mexico
Hausam, Robert R Sedalia
Hayes, Lawrence L Kansas City
Hayes, Nancy J Mountain Grove
Hecker, Jos E Poplar Bluff
Henselmeier, Dale M Bridgeton
Hernandez, J. Humberto California
Heutel, Lee B St Louis
***Hevel, Robert W** Palmyra
Hite, Dennis E Lebanon
Hoffmann, Alan L Kansas City
Hofmeister, Roger W Columbia
Holcomb, John K Cape Girardeau
Holzem, Craig S Washington
***Honderick, Richard T** Springfield
Howell, David T Florissant
Hrabik, Brent Tarkio
Hubbard, Sally L Springfield
Huffman, Thos L Branson
Humphrey, James D Mound City
Hunter, James K, Jr. Fairfax
Icaza, Ramiro Jackson
***Isaacs, Victor E** Scott City
Jackson, Max G Kansas City
Jary, Mark L Ozark
Jenkins, Edward R Waynesville
Johnson, Joseph E Kansas City
Johnson, Lent C Hannibal
Jones, Keith D Warrensburg
Jones, Stanley G, Jr. Sikeston
Kairuz, Bartolome C St. Louis

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*Doctor of osteopathy.

Kanne, Marty A Kansas City
Kappesser, Netajean G St Louis
Kasten, Mark C Cape Girardeau
Kenney, Douglas R Clinton
Kessler, William D, Jr. Joplin
Kiekhaefer, Theodore C St. Joseph
Kimlinger, William R Jefferson City
Kincaid, Rosa A Sikeston
Kinder, Doyle O Springfield
Klein, Kendel L Mt. Vernon
Klingner, Geo M, Jr Springfield
Koehn, Douglas P Marshall
Koon, Benny H Bolivar
Kruse, Carl R Palmyra
Laatsch, Robt H Poplar Bluff
Lauber, Joseph J St Louis
Legler, Larry E Independence
Leroux, Gene H Doniphan
Lischwe, Daniel H Bridgeton
Lofgreen, Craig S Kansas City
Long, Timothy P Marthasville
Lueckenhoff, Rebecca R Jefferson City
Luerding, Jeffrey A Kansas City
Lutkewitte, Jos F Ste Genevieve
Madden, Michael L Kansas City
Majure-Lees, Joyce E Stilwell
Markway, Gregory A Independence
Marshall, William G Glasgow
Martin, Mark W Lee's Summit
Martin, Robert A West Plains
Masters, Edwin J Cape Girardeau
McFarland, Rodney J Neosho
McKinney, William D, Jr. Belleview
Mehaffy, Orville A Joplin
Meier, Francis X Jefferson City
Memken, John A Hannibal
Menchetti, Donald E Springfield
Meyer, Jerry L Concordia
Miller, Burney A Blue Springs
Miller, William D St. Joseph
Mitchell, Thos J St. Clair
Molberg, Peter J Springfield
Molden, Chas A Bridgeton
Montes, Arturo C Florissant
Morgan, W. Tom , Jr. Columbia
Morton, Wayne L Osceola
Moseley, Brad Silver City
Mueller, Randall E Columbia
Munger, Michael L Kansas City
Myers, Carl M Platte City
Newbold, Steven E Kansas City
Newman-Koehn, Mica K Marshall
Nolph, Georgia J Columbia
Noor, Sidi Y St. Geneieve
O'Connor, John J St. Louis
O'Connor, Robert J Florissant
O'Keefe, Timothy Joplin
Ojascastro, Alejandro C St. Louis
Ortiguero, Leopoldo M St Louis
Osbourn, Richard A Fulton
Ostergaard, Daniel J Kansas City
Ouellette, David F Hannibal
Palen, James E Cape Girardeau
Papreck, K T Marshall
Paris, Wm H Bridgeton
Parks, William C Columbia
Patel, Natu B Bethany
Patterson, Donald R Joplin
Pennington, Michael S Springfield
Philgreen, Donald E Kansas City
Phillips, Ronald L Kirksville
Pifer, Lawrence H St. Joseph
Piker, K. Dewayne Springfield
Pimentel, Esperanza M St Louis
Pinkham, Chris M Kansas City
Pitney, Phillip W Louisiana
Poggemeier, Wm H St. Charles
Pon, Marcelino St. Louis
Porter, Walter N, Jr. Lenexa
Potts, Donald A Kansas City
Presley, Jimmy C Springfield
Preston, Bruce E West Plains
Prica, George , Jr Columbia
Price, Richard C Harrisonville
Radel, Steven M New Haven
Randolph, Bernard C St Louis
Rardin, Mary L Kansas City
Ratcliff, Keith M Washington
Reeder, Chas C Smithville
Renner, John H Kansas City
Reyes, Efraim Springfield
Reynolds, Susan K St. Louis
Rhee, Seoung E Richmond
Richardson, Geo A Union
Riley, Chas T Richmond
Robb, Christine A Grandview
Robbins, Thomas D Jefferson City
Roberts, Theodore W Sikeston
Rogers, H. Bryan St. Louis
Rosen, William K Springfield
Rosenquist, Chris R Cape Girardeau
Royce, Debra L Sarcoxie
Rues, Lawrence A Kansas City
Ryan, David Trenton
Salanski, Stephen C Lee's Summit
Sandberg, Chris B St. Joseph
Schmitz, Ralph A Monett
Schnurr, Thomas C Neosho
Schroff, Carle E Springfield
Schutz, John P Excelsior Sprgs
Scott, E. David Jefferson City
Scott, Kenneth F Clinton
Scully, Bruce D Clinton
Seale, Stuart A Springfield
Sells, Kenneth J Kansas City
Shaw, James T Hermann
Shaw, Robert D Willow Springs
Shields, Lawrence S Springfield
Shinn, Michael E Kansas City
*Sill, William St Peters
Silvers, L. Michael Kansas City
Sincox, Chas H Washington
Sitzmann, Bryan L Kansas City
Sklenar, Donald E St. Joseph
Smith, Claude F Willow Springs
Smith, Gilbert D Poplar Bluff
Soper, Wm D Liberty
Sparkman, Thomas C Cape Girardeau
Spence, Paul A Cape Girardeau
Spencer, Donald C Fulton
Spurney, Joe E Kansas City
Steenbergen, Michael Jefferson City
Steiner, Marvin P Independence
Stelmach, Walter J Kansas City
Stine, G. Wayne Springfield
Stone, Kenneth D Sikeston
Stringer, Kenton L Aurora
Stuerman, Lawrence G Louisiana
Suarez, Alberto Lee's Summit
Sword, Suzanne H Kansas City
Tanner, Robert H Jefferson City
Tedrow, Jeffrey R Bolivar
Thies, Jerome H Osceola
Thomas, Deborah G Cape Girardeau
Thompson, Frederick L Nevada
Thompson, Scott W Kansas City
Thompson, Susan Plattsburg
Till, Bennie N Poplar Bluff
Tobin, Marla J Higginsville
Treadwell, Randall E Alton
Turner, James D Washington
Turner, Kirby L Poplar Bluff
Turner, Scott A Osceola
*Turner, Timothy T Barrington
Van Zanten, Niko A Osceola
Vargas, Theodoro C Pacific
Wacker, Leo L St Louis
Walker, Ambrose T Thayer
Walton, J. Douglas Sikeston
Ward, Mark Neosho
Waterman, Franklin M Kansas City
Watts, Jane M Kansas City
Watts, Samuel M Aurora
Weiss, James J Jefferson City
*Wescott, Thomas P Holden
Weston, Kenneth G Columbia
Wheeler, Robt L Harrisonville
White, Barry B Puxico
White, Russell D Aurora
Williams, Paul A Kansas City
Williams, Paul A St. Louis
Wilson, David E Smithville
*Wilson, James W Springfield
Wilson, Timothy A Smithville
*Wilson, W. Timothy Springfield
Wood, Thos O Poplar Bluff
Workman, Geo M Hermann
Wulfers, Michael C Cape Girardeau
Wurm, Michael J Maryville
Wurr, Dieter H Arnold
*Yocum, Russell S Platte City
Yontz, David L Clayton
Young, Robt B Rolla

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*Doctor of osteopathy.

Zanol, John M Columbia

GE-GASTROENTEROLOGY

Allen, Mark J Kansas City
Barber, Gregory B Kansas City
Brand, Stanley N Kansas City
Brock, Arthur L Independence
Butt, James H Columbia
Coleman, Matthew J Cape Girardeau
Coleman, Terrence W Independence
Cooper, Gary D Liberty
Cusworth, Robert St. Charles
Fedotin, Michael S Kansas City
Freeman, Michael R Cape Girardeau
Geisman, Richard A St. Peters
Gifford, David L Richland Hills
Ginsberg, B. William Kansas City
Gould, Ronald J St. Louis
Gurian, Lawrence E Springfield
Helzberg, John H Kansas City
Honaas, Trygve O Cape Girardeau
Hover, Alexander R Springfield
Jacobs, Walter H Kansas City
Jennett, Richard B Jefferson City
Khan, Altaf A St Louis
Kinsella, Edward D St. Louis
Kipfer, Robt E Springfield
Knight, Wm A, Jr. St Louis
Kouo, Louis Cape Girardeau
Landers, Burnell Kansas City
Lee, Wilfred Cape Girardeau
Libel, Roy D Springfield
Maple, Francis M Springfield
Margolis, David M St. Louis
McCullough, Joseph E Kansas City
Mentgen, Carl N Springfield
Narayan, Dilip L Chesterfield
Pattison, Charles P Kansas City
*Schneider, Horace L Cape Girardeau
Shell, William C Sikeston
Sylvanovich, W. Richard St. Louis
Taormina, Marc K Independence
Woltjen, John A Kansas City
Wooten, Michael B Springfield

GP-GENERAL PRACTICE

Akremi, Janet E Greenfield
Allan, James R Four Seasons
Anderson, Paul B Neosho
Arribas, Aurora I Kansas City
*Bader, Larry W Columbia
Baldwin, Theodore R Excelsior Spgs.
Baumann, Albert R Steelville
Bradley, Wm W Centralia
Butts, James D Rolla
*Bynum, Robert L Ashland
Campbell, Albert J Sedalia
Campbell, James E Macon
Campbell, James W Advance
Carleton, Chas E Farmington
Carlin, Albert L Stanberry
Carnell, Billy M Buffalo
Carpenter, Wallace Rock Port
Choudhury, M. Hasan Houston
Coffee, Amos L Willow Springs
*Combs, Marvin D Albany
Comeau, Richard J Dexter
Conant, James F St. Joseph
Cooper, Robert W Camdenton
Crosthwait, Edward L Springfield
Dabbs, Wilbur D Neosho
Danganan, Manuel S Doniphan
*Dean, Elizabeth E Rock Port
Dettmer, Robt F Ironton
Dudik, Randall G St. Joseph
Eldenburg, Donald O Sedalia
*Ennis, James R Holts Summit
Fairchild, James F Perryville
Finch, William O Anahuac
Folkner, Albert L Warrensburg
Frein, Donald E Harrisonville
Frissell, Dan H, Jr. St. Genevieve
Garrison, Theodore W Camdenton
*Gayle, David R Piedmont
*Gayle, Richard E Piedmont
Grable, James D Cape Girardeau
Gunn, Jack Versailles
Hamilton, Wm P Aurora
Hayden, Melvin R Camdenton
Haynie, William W Butler
Heath, Jimmy D East Prairie
Holley, Donald B Camdenton
Howell, Billy D Brookfield
Howitt, William J Springfield
*Hutchins, Sherry S Savannah
*Irinyi, Elmer T Gower
Jahanian, Iraj Springfield
Karraker, Alvan G Farmington
Kauffman, Ruth Versailles
Kenney, Roy E Neosho
Knipschild, Bedford F Marshall
Ladd, Charles B St. Louis
Lai, Hsien-Ell Higginsville
Lankford, Harold D Mexico
Lichty, Chas A Shelbina
*Lillig, James F Kansas City
Long, Curtis W Butler
Lopez, Ruben E Hayti
Lyle, Robt R Versailles
Magaw, David C Everton
Magruder, Lyell M Nevada
Maravilla, Levy M St Louis
McFadden, Gene A Waverly
Menne, Marvin C Ironton
Miller, William D Dexter
Moore, Candice A Topeka
Moore, Michael R West Plains
Morehead, Wm E Malden
Morris, John J Columbia
Morrison, Thos A Aurora
Myers, James M Rolla
Ozenberger, Larry A Plattsburg
Painter, Andrew E Portageville
Pavlu, Robert R Waverly
*Pewitt, Charles S Jackson
Rapp, Earl L Hannibal
Raynor, Richard C Marshall
Reed, Glen H Appleton City
Robertson, Wm D Poplar Bluff
Sargent, Alden P Sikeston
Schaaf, Robert O Gower
Scowley, John E Richmond
Shanahan, Philip J St. Louis
Singh, Daljeet R Higginsville
Smith, Robt W Brookfield
Smith, Wm J Windsor
Stuart, Danl D Brunswick
Sweiger, James H Plattsburg
Taylor, Steve J Mexico
Vinyard, Jack L Joplin
Wall, Joe A Houston
Won, Russell St. Louis
Worley, Charles A Laurie

GPM-GENERAL PREVENTIVE MEDICINE

Michelson, Richard B Kansas City

GS-GENERAL SURGERY

Abella, Ben Zulueta Kansas City
Aeder, Mark I Kansas City
Afuwape, Emanuel A E. St Louis
Albano, Benj I Crystal City
Alexander, George K St. Louis
Allen, Brent T St. Louis
Almiron, Osias A House Springs
Altepeter, H. Martin St. Louis
Ancheta, Apolinario A Springfield
Anderson, Charles B St. Louis
Andres, Edward H St Joseph
Andrus, Charles H St. Louis
Apostol, Andres G Monett
Arbab, Ali A Kansas City
Arenos, Proceso T St. Louis
Arnold, Kenneth J Chesterfield
Arribas, Romeo F Blue Springs
Ashley, Michael E Springfield
Ashley, Thos E Springfield
Auer, Arthur I St Louis
Ayvazian, Vatche H St. Louis
Babka, Joseph J St. Louis
Baik, Kenneth Y Marshall
Barbee, Chas W Columbia
Barr, Glenn A Kansas City
Barragan, Hector D St. Louis
Bartlett, Hugh C Rolla
Bass, Barry J Rolla
Baue, Arthur E St. Louis
Bautista, Rogelio L Moberly
Beckman, Robert F St. Louis
Beggs, Charles W Liberty
Beheler, Edward M St. Joseph

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*Doctor of osteopathy.

Behrends, Steven H Kansas City
Behrens, Donald T St Louis
Behrens, Gerald L St. Louis
Benage, Clarence M St. Louis
Bennett, Kenneth J St. Louis
Bentlage, Charles H Joplin
Bergmann, Daniel J St. Peters
Berwald, David M Bridgeton
Bessey, Palmer Q St. Louis
Betz, Robert F Neosho
Bhattacharya, Arjun St Louis
Billy, Lawrence J Florissant
Binnington, H B St Louis
Birnbaum, Elisa H St. Louis
Bizek, J L Aurora
Blackwell, F. Michael Sikeston
Blank, Michael K De Soto
Blanke, Thomas J St. Louis
Blumenthal, Mark F Bridgeton
Boullier, John A Webster Groves
Brabbee, Gregory W St. Louis
Branch, Walter D, JR Kansas City
Breeding, Lyle G Columbia
Brunt, L. Michael St. Louis
Buben, Robt W Hannibal
Buettner, John Brigham Chesterfield
Bukstein, Michael J Hannibal
Bussmann, Carl E Bridgeton
Butler, Stephen M Hannibal
Cabrera, Tomas V St. Peters
Calman, Carl H St. Louis
Carter, James R Neosho
Cassat, James D Washington
Castaneda, Marco A Bridgeton
Catanzaro, Rudolph E St Louis
Chavez, Salvador St. Louis
Cheuk, Shu-Sum Chesterfield
Christiansen, Stephen D Springfield
Christy, John P Poplar Bluff
Chu, Peter Y Kansas City
Chung, Kap Eun Fredericktown
Chung, T. David Poplar Bluff
Cohen, Marvin C Kansas City
Cooper, James F Bridgeton
Cordonnier, James K Springfield
Corrado, Joseph A Mexico
Corry, Francis M Springfield
Coscia, Robert L Springfield
Cotner, Mark S Joplin
Craig, Richard O St Joseph
Craighead, Michael L Jefferson City
Crighton, John C Springfield
Crisp, N. Denney Independence
Critchlow, J. Thomas Mexico
Daake, John W, Jr. St. Louis
Dandridge, Walter C Joplin
Denk, Alan F St. Louis
Dexheimer, Frank R Columbia
Dillard, Burl M St. Louis
Doerhoff, Alan R Jefferson City
Doerhoff, Carl R Jefferson City
Doering, Robt W Kansas City
Donovan, John F St Louis
Duff, William M Rolla
Egan, Robert C St. Louis
Esparrago, F R Monett
Evans, Joseph C, Jr. Independence
Evans, Lawrence L Kansas City
Exarhou, Klark St Louis
Exon, C S Jefferson City
Fabito, Daniel C St. Louis
Fallon, Richard H St. Louis
Fink, Leroy L St. Louis
Floro, Kenneth E, Jr. St. Louis
Floro, Mariano N Florissant
Foreman, Phillip B Hannibal
Fotopoulos, Chris K DeQueen
Frohman, Boris Sikeston
Fry, Robert D St. Louis
Garvin, Paul J St. Louis
Gavini, Rajendra R St Louis
Georgi, Basil A Brooklyn
Gerowin, Lance St. Louis
Gibson, James D Springfield
Gieselmann, James W Poplar Bluff
Glenn, Edward A Louisiana
Goldfarb, Alvin St. Louis
Gomez, Cesar A St Louis
Gosek, Marek J Warrensburg
Graff, Ralph J St. Louis
Guerra, Gaston G Kansas City
H'Doubler, Charles Springfield
H'Doubler, Francis T Springfield
H'Doubler, Peter B Springfield
Hahn, Bruce H Lee's Summit
Hanna, Hugh A Warrensburg
Hansbrough, Eugene T Poplar Bluff
Hardman, William A Springfield
Harms, James F Nevada
Harris, Hugh S, Jr. Columbia
Hayek, Michael E St. Louis
Heeb, Max A Sikeston
Helfrich, Loring Sikeston
Helling, Thomas S Kansas City
Herrmann, Virginia M St. Louis
Hill, Ronald T Dexter
Hoehn, John P, III St. Louis
Hornbostel, Phillip M Sedalia
Horochowski, Alejandro Sedalia
Hubert, John P, Jr. Ashland
Humphrey, Loren J Columbia
Hunsley, Perry U Branson
Hunt, Robert S Cape Girardeau
Hurley, Joseph J St. Louis
Ivins, Gregory K Fulton
James, Kathleen M St. Charles
Jefferis, Kenneth R Maryville
Jensen, Joshua E, II St. Louis
Johnson, Frank E St. Louis
Joyce, Rex M Kansas City
Julien, Rene St. Louis
Kaiser, George C St. Louis
Kakaiya, Dilip H Kennett
Kamada, Tsutomu O'Fallon
Kaminski, Donald L St. Louis
Kampfe, Paul W St. Charles
Kang, Young M West Plains
Kasten, Melvin C Cape Girardeau
Keltner, Raymond M, Jr. St. Louis
Kim, Tae S Crystal City
Kinder, Jerry L Cape Girardeau
King, Frank K Hayti
King, Richard H Clinton
Kingsbury, Robt J St. Peters
Klippel, Allen P St. Louis
Knepper, Paul A, III St. Joseph
Knight, James W St. Louis
Koivunen, Debra G Columbia
Koontz, Paul G Kansas City
Kouchoukos, Nicholas T St. Louis
Krajcovic, David P Chesterfield
Kramer, Jeffrey B Prairie Village
Krause, G. Lynn , Jr. Chesterfield
Kraybill, William G St. Louis
Kwoun, Soung O Bridgeton
Lane, Charles A Hannibal
LaHue, William C Lexington
Lerwick, Everett R St Louis
Levy, Jerome F St Louis
Liang, Jing C Independence
Limpiphiphatn, Dhajphong Perryville
Lockhart, Charles E Springfield
Londe, Alan M St. Louis
London, Stanley L St. Louis
Long, W. Steven St. Joseph
Lopez, Marvin J St. Louis
Lopez-Plata, Roberto Kansas City
Lowe, H. Arch , Jr Springfield
Ludwig, Mark A St. Louis
Lugo, Saml St Louis
Lundman, Hugh Springfield
Madrid, Dominador O St Louis
Marr, Garrett L Kansas City
Martin, Clarence A Joplin
Mayuga, Laureano G Cabool
McCanse, Andrew No. Kansas City
McCroskey, Lon C Kansas City
McGinty, Chas P Cape Girardeau
McGinty, Frank H Cape Girardeau
Meiners, David J St. Louis
Metzler, Michael H Columbia
Meyer, Robert C St. Louis
Meyer, Wayne W Bridgeton
Meyers, Jerry R St. Peters
Miedema, Brent W Columbia
Mitchell, Franklin L Columbia
Moffe, Thomas C Springfield
Monafo, William W St. Louis
Moore, David L Kansas City
Morehouse, Paul D Washington
Mosley, Julian C St Louis
Mrosak, Daniel R Lexington
Muhm, Harvard Y St Charles
Mulder, George D St. Joseph
Mutchnick, Norman Kansas City

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*Doctor of osteopathy.

GYN-GYNECOLOGY

Nathan, Lester J St. Louis
Near, David M Florissant
Nelson, Paul W Kansas City
Nichols, W. Kirt Columbia
Niesen, Frank J St Louis
Niesen, Thomas E Chesterfield
Nigh, Chas A St. Louis
Nigro, Thomas L Kansas City
Nourbakhsh, Mahmoud M Kansas City
Nwaobasi, Sam Florissant
O'Farrell, Thos P Kansas City
O'Neal, Lawrence W St. Louis
O'Sullivan, Danl F St Louis
Occeno, Victor G Cassville
Olive, G. Chapman Springfield
Oliver, George A Farmington
Olson, Richard O St Charles
Ong, Eng L St. Louis
Parikh, Sharad P Florissant
Parks, Charles St. Louis
Parulekar, Dilip G Fulton
Peick, Ann C Poplar Bluff
Pennell, Richard C St. Louis
Perez, Adamor R St Louis
Peters, Walter R Columbia
Petit, Carl A Osage Beach
Philpott, Gordon W St Louis
Pitsinger, N. Bruce Chesterfield
Pontillas, Job B Perryville
Previti, Vincent Springfield
Pruett, Don S St. Louis
Radford, Diane M St. Louis
Rao, Carlo Florissant
Reardon, Thomas M Kansas City
Reese, Jeffrey C Chesterfield
Reese, Jon A Springfield
Reister, Philip D Kansas City
Rendleman, Geo F, Jr. St Louis
Reyes, Luis A Arnold
Richards, Frank O St Louis
Ridenhour, E. Gene Columbia
Rinehart, Gregory C St. Louis
Rodes, Ned D Mexico
Rodriguez, Gregorio L Charleston
Rodriguez, Ubaldo R St Louis
Roh, Joseph J Independence
Rosen, Charles B Kansas City
Rubin, Brian G St. Louis
Runez, Manuel W Maryville
Safley, Thos J Independence
Santiago, Felix R Wilmington
Sauer, Donald C St. Louis
Schaefer, Glennon S St Louis
Schlarman, David E St. Louis
Schmitt, Philip J St. Louis
Schneider, Thos A St Charles
Schokker, Johannes Jefferson City
Schuh, Marlys E Creve Coeur
Scott, Joni C Springfield
Seabaugh, Wm L Cape Girardeau
Seralathan, Ramasamy Trenton
Shands, Courtney , III St. Louis
Sheehan, Paul J Bridgeton
Shieber, Wm St. Louis
Shine, Thomas E St. Louis
Shook, John W Kansas City
Shoults, Nicholas F Springfield
Sicard, Gregorio A St. Louis
Sisson, Richard G St. Louis
Skibba, Joseph L Columbia
Solomon, Harvey St. Louis
Spray, Thomas L St. Louis
Standiford, Steven B Columbia
Stark, Karl R Kansas City
Steiling, Sylvia A St. Louis
Stoneman, William , III St Louis
Stoy, Robt P Columbia
Stricker, Eamil A Rolla
Stubbs, Thomas R West Plains
Sull, Won-Jong Sedalia
Swetnam, Jeffrey A Dyersburg
Tang, Teodoro Salem
Tenorio, Arturo A Stanberry
Terry, Boyd E Columbia
Terschluse, David A Bridgeton
Thiele, Otto K St Charles
Thompson, Eric Columbia
Thornton, Fred H Sikeston
Tompson, Robt V Moberly
Torres, Paul Kansas City
Trinidad, Hermanito R Chillicothe
Troop, Bryan R St. Louis
Tucker, Geo L Chesterfield
Turner, William A Nevada
Underwood, Johnson , III Kansas City
Ungvari, Jos C St Louis
Vadlamani, S. M. St Louis
Verzola, Eufemio G Herculaneum
Villahermosa, Juanito L Savannah
Villarama, Antonio P High Ridge
Visner, Sandra L Kansas City
Waltz, James R Liberty
Webb, John M Kansas City
Weinand, Ernest E St Joseph
Wells, Samuel A, Jr. St. Louis
Werner, F. Scott Kansas City
Westerman, Robt N St Louis
Westfall, Susan H Chesterfield
Wetzel, Gus S Clinton
Wilbers, Raymond H Mexico
Willcoxon, Robert L Joplin
Williams, Charlie B, Jr. West Plains
Willman, Charles R St. Joseph
Willman, Vallee L St. Louis
Windmiller, M. Eugene Columbia
Wittler, Harry A St. Louis
Wittmer, Marc R Springfield
Wonder, Donald Branson
Woods, John J, Jr. St. Louis
Yap, Mardonio J Florissant
Ylagan, Amando , Jr. St. Louis
Young, Robert A Chesterfield
Zacharias, Kulangara P Columbia

GYN-GYNECOLOGY

Fuchs, Geo J Columbia
Grimes, Elwyn M Kansas City
Hausheer, Herman J Independence
Kratz, Paul E Cape Girardeau
Patterson, Donald C Columbia
Pingelton, William B Columbia
Roberts, Howard H Joplin
Watson, Trevor F Columbia
Williams, Carol F St. Louis

HEM-HEMATOLOGY

Abdou, Nancy L Kansas City
Bayer, William L Kansas City
Carter, Robert L Joplin
Davidner, Mark L Kansas City
Fleming, Allan R Kansas City
Fracasso, Paula M St.Louis
Geier, Larry J Kansas City
Grant, Ruth Springfield
Hanson, Karl H Kansas City
Loftus, Loretta S Kansas City
Minkoff, I. Monica St Peters
Monaghan, Greg G Columbia
Muscato, Joseph J Columbia
Muscato, Mary S Columbia
Neu, Leo T, Jr Springfield
Peterson, Jay T Kansas City
Ratkin, Gary A St. Louis
Weigand, Robert T St. Joseph
Whittenberger, Brock P Cape Girardeau

HNS-HEAD & NECK SURGERY

Seabaugh, Janice L Mexico

ID-INFECTIOUS DISEASES

Belshe, Robert B St. Louis
Brewer, Joseph H Kansas City
Fried, John S Overland Park
Gerecht, Wolfe B Springfield
Gupta, Mala R Kansas City
Haddow, Alastair D Springfield
Kimbrough, Robert C, III Springfield
McKinsey, David S Kansas City
Smith, David Lambuth Kansas City
Westblom, T. Ulf St. Louis
Winton, Mark D Jefferson City

IM-INTERNAL MEDICINE

Abbott, David A St. Louis
Abel, Charles C St. Louis
Abelardo, Miguel I St Louis
Abinoja, Conrado B St. Louis
Adams, Robert B Joplin

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*Doctor of osteopathy.

IM–INTERNAL MEDICINE

Aguinaldo, Jaime A St Louis
Ahadi, Abd U St Louis
Ahern, Archibald M St. Louis
Ahmad, Naseer St. Louis
Aitken, Louis F St. Louis
Aker, Umit T St. Louis
Albright, Patti W Kansas City
Alegre, Jorge M Chesterfield
Allen, Thomas P Kansas City
Alonso-Yague, Pascual Florissant
Alvarez, Ulises C Florissant
Ammatelli, Francis J Kansas City
Andes, Elizabeth A Kansas City
Andrews, Paul E Springfield
Anslinger, David L Chesterfield
Apprill, Phillip G St. Louis
Atwood, Steven D Springfield
Auner, Cecil R Springfield
Avioli, Louis V St. Louis
Aydt, Sarah A Cape Girardeau
Aylward, Howard J, Jr. St. Louis
Azan, Kenneth N Sedalia
Back, Donald K Springfield
Backstrom, Jay T Kansas City
Bade, Bruce Moberly
Ballal, Hebri S St. Louis
Ballard, Dewey P St Joseph
Banerjee, Dilip Washington
Banton, M. Roman St. Louis
Barlow, Val John Chesterfield
Barnes, Larry G Neosho
Barrow, Jack St Louis
Bartell, Michael F St. Louis
Bateman, Timothy M Kansas City
Bauer, Daniel J St. Louis
Bautz, James B Kansas City
Bauwens, Daniel B Chesterfield
Beato, David L St Louis
Bender, Walter L Kansas City
Benedict, William W Chesterfield
Bentley, John D Springfield
Berdy, Susan S St. Louis
Berkowitz, Ellis R St. Joseph
Bernabe, Ofelia M St. Louis
Bernstein, Aaron M St Louis
Best, John A Chesterfield
Bettasso, Bernard F Joplin
Bettonville, Peter V St. Louis
Betz, Richard J Neosho
Biggs, Alfred D, Jr. Kansas City
Birge, Clifford A Richmond Hghts
Blum, Donald A St. Louis
Boldt, Thomas H Bridgeton
Bonsanti, Robt L Bridgeton
Boonshaft, Benje St Louis
Borja, Egbert R Springfield
Borowsky, Benj A St. Louis
Borrego, Raul A Farmington
Borts, Michael R St. Louis
Boulware, William T Chillicothe
Bowe, Christopher C St. Louis
Bowen, William G St. Louis
Bowles, G R St Louis
Bowlin, Steven K Kansas City
Boyer, Peter A Jefferson City
Brandwin, Leslie M St. Louis
Braun, Alan L Jefferson City
Braun, Sheldon R Columbia
Braverman, Abe E Kansas City
Braverman, Alan C St. Louis
Bregant, Robt E Jefferson City
Brinkman, Robert A Chesterfield
Broaddus, Loren E Springfield
Brockman, M. Douglas Springfield
***Brocksmith, James T** Columbia
Broun, Goronwy O, Jr. St. Louis
Brown, Barry D St. Louis
Brown, Frances S Kansas City
Brukardt, Diane T Columbia
Bryant, T J Kansas City
Budd, John J, Jr. St. Louis
Burmeister, R. William St. Louis
Burns, Edward L St. Louis
Burns, Thos W Columbia
Butin, Richard E Kansas City
Butsch, Richard H St. Peters
Cabral, Galileu St. Louis
Caciolo, Carlo P St. Louis
Cajili, Antonio T St Louis
Caldwell, Fred M Poplar Bluff
Calhoun, Kirk A Kansas City
Calhoun, Terry L Kansas City
Camp, Alan D Bridgeton
Campbell, J. William St. Louis
Carden, Juan O St. Louis
Carmody, John P St. Louis
Caruso, Alfred C Kansas City
Cary, John M Chesterfield
Chanasue, John A Florissant
Chandra, Mahesh Independence
Chandramohan, Nanjappa Carthage
Chapman, C. Larry Columbia
Chase, Larry K Springfield
Chaudhuri, Tapan K Raytown
Chellappa, Danu Joplin
Chern, Mou S Ava
Chernoff, Selbert G Lee's Summit
Chin, Mark Maw-Chang Chesterfield
Chinsky, Murray St. Ann
Chouinard, Michael P Sikeston
Christensen, Harold L Springfield
Clark, David P Columbia
Clark, Gail L Chesterfield
Clark, Robert C St. Joseph
Cline, Daniel M Kansas City
Coates, James G St. Charles
Cochran, Thos E Springfield
***Cohen, Donald L** Kansas City
Cohen, Hillard K St Ann
Conway, Philip G St. Louis
Copp, Ralph St. Louis
Coppinger, Thos A Kansas City
Corder, James C St. Louis
Couchonnal, Guillermo Shawnee Mission
Cramer, Quentin Kansas City
Crespin, Stephen R St Louis
Crie, J. Stanley St. Joseph
Crighton, Kent A Cassville
Cruz, Christopher T St. Louis
Cruz, Sergio G Monett
Culver, Perry J, Jr. Kansas City
Cunningham, Edwin J Chesterfield
Cunningham, Richard D Springfield
Curry, Michael J St Charles
Dames, Richard J St. Louis
Daniels, John S St. Louis
Dankner, Arnold Chesterfield
Davis, Alexander C Kansas City
Davis, J. Lawrence St. Louis
Davis, Thomas P, III Springfield
Deane, Louis V, Jr. St. Louis
Deardeuff, Dwight L Rolla
Deckard, Shelby W Springfield
***Deffenbaugh, Larry D** Joplin
Delcambre, Marie A Kansas City
Dembinski, David R Kansas City
Dexter, J. Kent Springfield
DeFelice, Charles E Cape Girardeau
DeFeo, Frederick G Kansas City
Dickerson, William J Osage Beach
Diemer, Thomas S Cape Girardeau
Diestelhorst, James A St. Louis
DiPasco, Donald J St. Louis
Dolan, Renee C Town & Country
Dorton, Robt K St Louis
Dorzab, Linda L Overland Park
Duff, James E Springfield
Dwyer, James G St. Louis
Dwyer, Joseph C Lima
Dzur, James R Cape Girardeau
Eck, Birkle St Louis
Edwards, Shelley J Kansas City
Emons, Matthew F St. Louis
Enriquez, Roman S Kansas City
Esther, James H St. Louis
Eubank, Wm Y Leawood
Fajatin, Romulo J St. Charles
Farnham, Milo M Independence
Faron, Mark A Chesterfield
Farrell, John S Bridgeton
Favors, Adolphus C, Jr. St. Louis
Feldman, David St. Louis
Ferguson, John L Springfield
Fernandez, Mark A Platte City
Ferrara, Robert P St. Louis
Figueroa, Eliseo O St Louis
Fischer, Robert St. Louis
Fisher, Linda St. Louis
Fishman, Norman Chesterfield
Fitch, Coy D St. Louis
Fleming, David A Moberly
Fleming, J. Will , Jr Moberly
Flicker, Michele R Kansas City
Flotte, Sylvester A St Louis

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*Doctor of osteopathy.

IM–INTERNAL MEDICINE

Flury, Kirk E St. Louis
Fogarty, William M, Jr. St. Louis
Fouts, Dallas B, Sr. Independence
Fowler, Wayne L, Jr. Kansas City
***Frank, Robert A** Kansas City
Franks, Elliott L Kansas City
Fraser, Richard A Poplar Bluff
Frawley, Thomas F St. Louis
Frederickson, Neil W St. Louis
Frey, Jeffrey P Columbia
Froehlich, Thomas W Springfield
Gafford, Franklin H, IV St. Louis
Galant, Mark R Belton
Gale, Arthur H St. Louis
Galvez, Sisenando P Marceline
Garcia, Kathleen M Clayton
Garfinkel, Bernard T St. Louis
Garriga, Francisco J Florissant
Gatchalian, Felicitas Z St. Louis
Gedney, Wm B Valley Park
Gendel, Jonathan Lee's Summit
Gerhardt, Donald C Columbia
Gibson, Paul H St. Louis
Gilbanks, Marjon M Independence
Gill, Paul J Springfield
Gillispie, John L Branson
Ginardi, Donald E Kansas City
Ginther, James W, Jr. St. Louis
Giorgi, Lee V Kansas City
Glazer, Melvin L Kansas City
Godwin, Lehman W Springfield
Goldberg, John M Kansas City
Goldman, Arnold M St. Louis
Goldman, Barry C Kansas City
Goodenberger, Daniel M St. Louis
Goodwin, J. Wendall Springfield
Gordon, Glenn L Mexico
Gordon, Mark E Kansas City
Gottlieb, Charlene C St. Louis
Grady, Ronald K Chesterfield
Grant, John M St Louis
Grant, Neville St Louis
Gray, Gary J St Louis
Greenlaw, Cal W Chillicothe
Gutierrez, Anthony C Kansas City
Gutierrez-Medina, Ernesto Florissant
Gutwein, Michael B St. Louis
Guyol, William B, Jr. St. Louis
Gwin, Edward Springfield
Ha, Richard J Hannibal
Haas, Harry D Blue Springs
Hagemann, Margarethe H St. Louis
Hagen, Garrett A St. Louis
Hale, Thomas H Manchester
Halloran, Mark J St. Louis
Halpin, Stephen E Hannibal
Hamburg, Eric D Farmington
Hamburger, Stephen C Shawnee Mission
Hammerman, Marc R St. Louis
Hantman, Stephen L St. Louis
Hardy, Patrick J Florissant
Hardy, Samuel W St. Louis
Harlow, Richard J, Jr Belton
***Harris, William D** Kansas City
Harshman, David M St. Louis
Harwell, J. Lee Columbia
Hastings, Thomas F Mexico
Havaldar, Kanti L Maryville
Hawatmeh, Sam S St. Louis
Hawkins, John W Independence
Hayes, Stanley P Springfield
Headrick, John A Lake St. Louis
Heaney, Robert M St. Louis
Hegde, Korgi V St. Louis
Heidbrier, Edward W St. Louis
Heim, Carissa M Houston
Heins, James N St. Louis
Hellam, Duane C Springfield
Hellman, Richard Kansas City
Hendrickson, Barry L St.Louis
Henry, Jos E Shawnee Mission
Herfkens, Kenneth D Springfield
Hess, John P St. Louis
Hill, M. Robert St. Louis
Hinrichs, James H St. Charles
Hintze, Paul F Chesterfield
Hoeman, Michael D Springfield
Hoeper, Samuel D, Jr. Grandview
Hoffman, Leanna M Hamilton
Hoffmann, Sandra S St. Louis
Hogan, Cornelius E St. Louis
Hogan, John R St Louis
Honeycutt, Pamela J Columbia
Horine, Jon A Kansas City
Hruska, Keith A St. Louis
Hu, Raymond J St. Peters
Hubert, John W Bridgeton
Huck, Richard F, Jr. St Louis
Huckstep, Robt A Farmington
Huggins, Albert M St Louis
Hulbert, Bernard St Louis
Husted, Frederick C Springfield
Hyde, Rita M Kansas City
Hyers, Thomas M St. Louis
Inman, Max M Chesterfield
Irvin, William S Columbia
Jackson, Dorothy J Blue Springs
Jacoby, Michael R.K. Kansas City
Jain, Savitri G St. Louis
Jamaluddin, Mohideen A Festus
Jantz, Keith Kansas City
Jarvis, Cathy C Florissant
Javdan, Ron Chesterfield
Jayamanne, Damasus S Jefferson City
Jayanandaiah, Hiremathada Hannibal
Jedlinski, Michael T Cape Girardeau
Johnson, Randy G St. Louis
Johnson, Richard L Kansas City
Johnson, Warford B, II Springfield
Jones, Elizabeth A Shawnee Mission
Jones, Harold L Springfield
Jotte, Richard P St. Ann
***Joubert, Paul M** Lee's Summit
Judge, Steven J Washington
Juergens, Wm G St Louis
Kakaiya, Ram M St. Louis
Kanagawa, Harold K Jefferson City
Kantor, Owen St Louis
Kardesch, Milton St. Louis
Karl, Michael M St. Louis
Karsh, Robt S St Louis
Kaufman, Robt L St Louis
Kauk, Bruce A N Kansas City
Kaup, Chandra S Florissant
Keairnes, Harold W Kansas City
Kelly, John J St Louis
Kendall, Charles A Independence
Kerkemeyer, George Hannibal
Khalil, Tamer G Springfield
Khojasteh, Ali Columbia
Kilgore, John W St. Louis
Kilo, Charles St Louis
Kim, Chul Poplar Bluff
Kim, S. Brian Springfield
Kime, Ricky L Cassville
King, Donald K St. Louis
King, M. Kenton St. Louis
Kinsella, Peter W St. Louis
Kinsella, Ralph A, Jr. St. Louis
Kipnis, David M St Louis
Kirkland, Jerry A Kansas City
Kissel, John H St. Louis
Kissell, Richard W Springfield
Kistler, W. David , Jr. St. Louis
Klachko, David M Columbia
Klearman, Micki St. Louis
Knowlton, Norman P, III Springfield
Koenig, Gary D Florissant
Kohler, Roy Springfield
Kopp, Kenneth R Lenexa
Kort, Arthur A St. Louis
Kraetsch, Robert E St Louis
Kreski, Kenneth C House Springs
Krewet, Frank A, III St Louis
Kuangparichat, Manoch Excelsior Spgs.
Kuebel, Richard J St. Louis
Kuhlman, Ralph F St Louis
Kunst, Edward J Ballwin
Laird, John M St. Louis
Lamb, Eileen St. Charles
Landau, David W St. Louis
Landsbaum, Charles J Jefferson City
Latif, Azhar Lexington
Lauderdale, William H Forsyth
Lauer, Danl J Kansas City
Lawrence, Willie E, Jr. Kansas City
LaMonda, Gary W Columbia
LaPietra, Martha M Lee's Summit
Lednicky, Jay A Lee's Summit
Leeper, Sidlee W Rocheport
Lehman, Robert B St. Louis
Leidenfrost, Ronald D Chesterfield

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*Doctor of osteopathy.

Leightner, William F St. Louis
Leitch, Steven M Springfield
Letizia, Wayne L Independence
Levanvo, William Joplin
Levitt, Joseph St. Louis
Levy, Morton A St. Louis
Lewandowski, Molly J Leawood
Lewis, Lawrence M St. Louis
Lieberman, David M St Louis
Liebhaber, Harvey St Louis
Lila, Aram Excelsior Spgs.
Lin, H T Moberly
Lindeman, John F Chesterfield
Llana, Angelo A St. Joseph
Lockard, Orlyn O St. Joseph
Loeb, Richard H Springfield
Loeppky, Carol B Columbia
Logan-Morrison, Beverly A St. Louis
Loggan, Michael B Liberty
Lohmar, Roland E Columbia
Long, Chester I Joplin
Long, Priscilla E Hannibal
Loomis, James F St. Louis
Love, Gerry A Liberty
Loveland, Richard D Hollister
Lovinger, Warren C, Jr. Nevada
Lubowitz, Herbert St. Louis
Lurie, Harold H Springfield
Lyons, Daniel F Springfield
Lyss, Carl A St. Louis
Maben, Sam E Kansas City
Maclaughlin, James C Joplin
Macleod, Angus St Louis
Magee, W. Edwin St Louis
Majors, Patrick F St. Louis
Maliszewski, James A Kansas City
Mallouk, Alexander G Kansas City
Mantell, Jack M Springfield
Marshall, Jay P, II Chesterfield
Martin, Chris J Columbia
Martin, J. William Washington
Mass, Joan H Florissant
Matthews, John I Jefferson City
Mayus, Joseph L Springfield
McCaffree, Mary K Jefferson City
McCarthy, Christopher St. Louis
McCluggage, Newton C No. Kansas City
McCool, James F St. Louis
McCormack, Robert E Kansas City
McDonald, Wallace St. Joseph
McGovney, Janice K Smithville
McKeel, Thos B Kansas City
McKinley, Lois J Kansas City
McLemore, Willie O Kansas City
McMillan, David L Neosho
McMillen, James J St. Joseph
McPhee, Mark S Kansas City
Meacham, Joseph A St. Louis
Mehra, Ravi St. Louis
Meldi, Dominic M Springfield
Meltz, Gary J St. Charles
Mendelsohn, Robert S St. Louis
Mentel, John J St. Peters
Metry, Donald J, Jr. Chillicothe
Mihalevich, John A, Jr Springfield
Miller, Chas , Jr. St. Louis
Miller, Dace L Springfield
Miller, Donald Jefferson City
Miller, Michael R Kansas City
Mills, Melissa J Kansas City
Minnigerode, Turner L Kansas City
Miskovsky, Emil F Bridgeton
Mitchell, Lynn D Columbia
Mitchem, Olevia Kansas City
Mohrman, Raymond F Bridgeton
Mohs, Frank R St. Louis
Molden, C. Scott St Louis
Monaco, Michael Kansas City
Montes De Oca, Julio St. Louis
Montgomery, Austin F St. Louis
Moore, John M Kansas City
Morgan, Charles H Springfield
Moriconi, William J St. Louis
Morris, J H Independence
Morris, R. William St. Louis
Morrison, Arlen E Chesterfield
Mortensen, Frede St. Louis
Morton, David J St. Louis
Motchan, Dennis G Bridgeton
Muegge, F. David Springfield
Mueller, Howard A Bloomington
Muhammud, Faquir St Louis
Mullen, Mary E Mexico
Mullins, John E Chesterfield
Murphy, Brian P Raytown
Murphy, Daniel J Bridgeton
Nanson, Duane Columbia
Narkiewicz, Lawrence S St Louis
Navato-Dehning, Cielo D Independence
Nayar, Gopal K Chesterfield
Neihart, Robert E Kansas City
Nelson, Donald C Springfield
Nicholas, Stephen P St. Louis
Nickell, Michael D Joplin
Niesen, Anna R St. Louis
Nix, J. Gustavo Bolivar
Nordlicht, Scott M St. Louis
Norland, Chas C St Louis
Novack, Mark A Chesterfield
Nulton, Carnie C Kansas City
Nyazee, Muhammad A Bridgeton
O'Dowd, Mary K Chesterfield
O'Keefe, James H, Jr. Kansas City
Ockner, Samuel A St. Louis
Ojile, Joseph M St. Louis
Olsen, Teresa A Springfield
Olson, James H Liberty
Onder, Robert F St. Louis
Orgel, S. Michael St Louis
Orlando, Louis A Kansas City
Ortbals, David W Chesterfield
Ortmeyer, Leroy F St. Louis
Osgood, Brian M Independence
Ovens, Lisa Springfield
Owen, Robt F St Louis
Packman, Robt C St. Louis
Paine, Robert Chesterfield
Palazola, Joseph M Kansas City
Paletta, Frank St. Louis
Paletta, Theodore L St. Louis
Paletta, Victor L Bridgeton
Panek, Judy L Kansas City
Paone, Douglas B Kansas City
Parker, Thos W St Louis
Parks, Deborah L St. Louis
Paskon, Seth Salem
Patel, Indu B Barnhart
Patel, Prakesh B St. Joseph
Peck, William A St. Louis
Pelican, George St. Louis
Penilla, Antonio R Bridgeton
Penkoske, Michaele M St. Charles
Pereira, MaryBeth St. Louis
Perez, Robert J St. Louis
Perll, Michael F Kansas City
Perlstein, Laurence F Florissant
Perryman, John C Kansas City
Peterson, John E Kansas City
Petruska, Paul J St Louis
Pfefer, Leland U Columbia
Pfefferkorn, David A Sikeston
Phillips, Wm J Chesterfield
Pickard, Clarence M Columbia
Pickering, Lee I Independence
Picus, Joel St. Louis
Pineda, Hector O St Louis
Pogson, George W, III Independence
Popp, Dennis A St. Louis
Porter, Charles B Kansas City
Postma, George S, Jr. Shawnee Mission
Potts, Dan E Chesterfield
Powell, Kenneth R Springfield
Prelutsky, David J St. Louis
Proskey, Vincent J Chesterfield
Purcell, Henry E St. Louis
Purcell, Richard D Springfield
Puro, Edward A Florissant
Qureshi, Abdul R St Louis
Raible, Michele D Kansas City
Raich, Robt A Kansas City
Raju, Niranjana Ste. Genevieve
Ramirez, Jose A St. Louis
Ramirez, Samuel G St Louis
Ramsey, Robt H Florissant
Randolph, Kerry A Springfield
Rangineni, Rajagopal St. Joseph
***Rankin, Wendell D** Joplin
Rau, Michael E Washington
***Ray, Curt L** Mission
Raybould, Michael W Kansas City
Razzaq, A. St. Louis
Reardon, Thos F St. Louis
Redington, James C, Jr. St Louis
Redmon, Conchita M Nixa

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*Doctor of osteopathy.

IM–INTERNAL MEDICINE

Reeder, Stephen M Springfield
Reh, Edward P, Jr. St. Louis
Remo, Jose' A, Jr. Sullivan
Reynolds, James A Chesterfield
Rhoads, Jack V Joplin
Rice, Karen H Jefferson City
Richards, Dean D, III Kansas City
Rigolosi, Ronald A Kansas City
Riner, Ronald N St. Louis
Rippe, William F St. Joseph
Ritter, C J Cape Girardeau
Roberts, John P St. Louis
Robinson, Nicholas F Kennett
Robinson, Ronald L Cape Girardeau
Rogers, James T Springfield
Romaker, Ann M Kansas City
Rope, Douglas M Kansas City
Rosecan, Marvin Belleville
Rosen, Howard M Kansas City
Rosen, Larry A Independence
Rosenberg, David S Florissant
Rosenwasser, Tamzin A St. Louis
Ross, Robert M Kansas City
Roth, John J St. Louis
Rother, Paul H St Charles
Rouse, Ernest T, III St Louis
Routburg, Mark S St. Louis
Roxas, Generoso P St. Charles
Russell, Nancy R Kansas City
Ruwitch, Joseph F, Jr. St Louis
Sale, Llewellyn , Jr. St. Louis
Salvaggio, Bruce H Kansas City
Samet, John M St. Louis
Samuel, George P Doniphan
Scanlon, Charlotte D Kansas City
Scheff, Robert J St. Louis
Schell, James A Columbia
Scherer, Stephen Kansas City
Schierman, Wm D St. Louis
Schlossman, David M Columbia
Schmid, Tania L St. Louis
Schmidt, Edwin H, III St. Louis
Schnarr, William St. Charles
Schneider, Paul G St. Louis
Schneider, Robert J St. Louis
Schoenberger, John R Cape Girardeau
Schondelmeyer, R. Wade Columbia
Schonfeld, Gustav St Louis
Schuessler, Wolfgang P St Louis
Schuetz, Alfred St Charles
Schultz, Irwin St Louis
Schwartzman, Neil R Lebanon
Schweitzer, James M St. Louis
Scott, C. Alan Marshall
Scott, Michael R Springfield
Scott, Robert W Springfield
Scott, Thomas E Kansas City
Sertl, James F St Louis
Shalet, Malcolm F Kansas City
Shapleigh, John B, II Chesterfield
Shatz, Burton A St Louis
Shea, James G Washington
Shen, Anthony S St. Louis
Shore, Bernard L St. Louis
Shuman, Robert B St. Louis
Shuttari, Mir F Columbia
Sides, Stanley D Cape Girardeau
Singh, Kuldeep Macon
Singhal, Gokul C St Louis
Singleton, John M, III Kansas City
Sinnett, Mark F Kansas City
Sislen, Donald R St Louis
Sisler, Maynard L Kennett
Sly, Anne K Kansas City
Smith, Dennis W Joplin
Smith, Kenneth B Washington
Smith, Ralph O Jefferson City
Smith, Reid C Kansas City
Smoller, Martin B St Louis
Snavely, Sharon R Kansas City
Sollars, Eric G St. Joseph
Sommer, Rand W St. Louis
Soonattrakul, Wuthisak Kennett
Sosna, Jacob P St. Louis
Soucy, John C St Charles
Spernoga, John F St. Louis
Spivack, Alan R Chesterfield
Sprague, Gita St. Joseph
Spriegel, John R Stevensville
Squitieri, Alphonse J St. Louis
Stahl, Lloyd D Kansas City
Stanford, Carol A Kansas City
Starke, Keith M St. Louis
***Steinbrecher, Janis M** Lee's Summit
Sterkel, Barbara B St. Louis
Sterkel, Richard L St. Louis
Stewart, James L Weatherby Lake
Strauss, Carl F Kansas City
Stronach, Linda L St. Louis
Stuber, Robert R St. Joseph
Stufflebam, Brian W St. Peters
Stufflebam, Robt E Springfield
Subramanian, S. Carthage
Sullivan, William W St. Louis
Suva, Morfeo M Springfield
Suwanabhand, Chalaw Butler
Suwannasri, Rudee St. Louis
Swaykus, Bernard T Bridgeton
Taege, Alan J St. Joseph
Talwar, Tara Chesterfield
Tanphaichitr, Kongsak St. Louis
Tansuwan, Chukiat Ferguson
Taylor, William K Springfield
Teeter, Brian H Joplin
Tepper, Arnold St Louis
Thoma, George E, Jr. St. Louis
Thurmann, Manfred St Louis
Tillinghast, Jeffrey P St. Louis
Titterington, Frank W Kansas City
Tobin, Garry S St. Louis
Tominack, Rebecca L St. Louis
Torontow, Raphael J Nevada
Toubes, Daniel B Kansas City
Troeh, Melvin R Independence
Trotter, W. Yates Springfield
Tucker, Leslie E Washington
Turner, Glenn O Springfield
Tuteur, Peter G St. Louis
Uchiyama, Robert C Chesterfield
Uhrig, Jack R Marshall
***Vale, Janett A** Kansas City
Valuck, Richard P, Jr. Hannibal
Van Amburg, Albert L, III Chesterfield
Van Voorn, Catherine M Columbia
VanGoidsenhoven, Guy E St Louis
Varma, Devendra K Poplar Bluff
Vatterott, Paul B, Jr. Chesterfield
***Venter, John L** Joplin
Verdught, Ammon L Lee's Summit
Vibulakaopun, Pairat Bonne Terre
***Vogelsang, Judith K** Kansas City
Voshall, David L Blue Springs
Wade, Kim C Kansas City
Wadsworth, Harry L St. Louis
Wagan, Primitiva C St. Louis
Wald, Stanley M St. Louis
Walden, James M Kansas City
Walker, Harvey , Jr. St. Louis
Walker, Melvin O, Jr. Springfield
Walsh, James W St Louis
Walsh, Martin J St. Charles
Wantuck, Donald K Springfield
Waterfield, Jim R Springfield
Webb, Karen B St. Louis
Welsh, Thomas E, III Mexico
Welton, Stephen T Sikeston
Wenneker, Alvin S St Louis
Werner, Harold V West Plains
Werner, William A St. Louis
Westhoff, David D Jefferson City
Weyerich, Noel F St Louis
Whitener, Miles C St Louis
Whiting, Richard B St. Louis
Whitman, Daniel S Kansas City
Wientzen, Arthur S Kansas City
Wilkins, Michael S Kansas City
Williams, George A St. Louis
Williams, R. Jerome , Sr. St. Louis
Williams, Roy J, Jr. St. Louis
Williams, Wendell N St. Louis
Wilson, Vicki R Kansas City
Wilt, David A Kansas City
Winer, Nathaniel Kansas City
Winnacker, John L Columbia
Wolanski, Eugene G St Joseph
Wolfe, John E Springfield
Wolff, Gerald A St Louis
Woolery, William G Sedalia
Wright, Jeffrey M St. Louis
Wright, William P St. Louis
Wuellner, David H Sedalia
Wurster, Mark W Kansas City
Wyatt, Ronald M St. Louis
Yadav, Sanjay S Kansas City
Yuhas, Michael E Joplin

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*Doctor of osteopathy.

Zacharewicz, Lisa J Kansas City
Zerr, Charles H Independence
Zimmerman, Herbert B St Louis
Zoffuto, Anthony C Cape Girardeau
Zylka, J. Michael St. Louis

N-NEUROLOGY

Abrams, Bernard M Kansas City
Adelmann, Eugene St. Louis
Ahmed, Iftekhar Kansas City
Allen, Arthur A, II Shawnee Mission
Appelbaum, James S Kansas City
Asher, Irving M Columbia
Awadalla, Sylvia St. Louis
Berg, Leonard St. Louis
Bettinger, Irene E Kansas City
Bhothinard, Bhisit Poplar Bluff
Black, Joseph T St Louis
Bonner, James S St. Louis
Breeden, Richard L Rolla
Briggs, Thomas B Springfield
Brownsworth, Ronnie D Springfield
Cantor, Harvey E St. Louis
Choi, Dennis W St. Louis
Crowley, Wm J Columbia
Dean, Philip D Washington
Dexter, James D Columbia
DeMarchena, Octavio Lynchburg
Dooley, Joseph M, Jr. Chesterfield
Downs, Mary K Springfield
Eliasson, Sven G St. Louis
Eyerman, Edward L St. Louis
Ferrendelli, James A St Louis
Ferry, Richard J St. Louis
Geller, Bruce D Kansas City
Goldring, James M Columbia
Habiger, Thomas G Springfield
Hackett, Earl R Springfield
Hanaway, Joseph St Louis
Hatlelid, J. Michael St. Louis
Hoffman, William F St. Louis
Hoffmann, Lee M Shawnee Mission
Hogan, Patrick A St Louis
Hooshmand, Ahmad Jefferson City
Horenstein, Simon St. Louis
Landau, Wm M St. Louis
Lee, David Y S Cape Girardeau
Legarda, Maria M Kansas City
Lin, Chi-Hsi Springfield
Luzecky, Michael H Springfield
Makos, Mignon M St. Joseph
Malkoff, Marc D St. Louis
Margolis, Robert P St. Louis
Matovich, Violet B Kansas City
McFarland, H. R. Kansas City
McLaren, David L Columbia
***Mellies, Steven D** Cape Girardeau
Morantz, Robert A Kansas City
Naseer, Riaz A St. Louis
Ortega, Steven A Joplin
Pearlman, Alan L St Louis
Peeples, David M Ballwin
Phillips, Daniel St. Louis
Quinn, Rodney D Springfield
Raichle, Marcus E St Louis
Reisler, David M Chesterfield
Reiss, Jeanne E Kansas City
Robinson, Jay G Kansas City
Rosenbaum, Herbert E St. Louis
Rowe, Vernon D, III Kansas City
Rymer, Marilyn M Kansas City
Sanchez, Abelardo B St. Louis
Sand, John J Kansas City
Satake, Robert L Kansas City
Schreiber, David J Alton
Schultz, Earl R St Louis
Shakil, Mohammad Cape Girardeau
Sher, Allyn L Columbia
***Sherrod, Glenn M** Bridgeton
Simowitz, Fredric M St. Louis
Sohn, Richard St Louis
***Stahly, Randall L** Cape Girardeau
Trotter, John L St. Louis
Tyndall, Robert J Springfield
Verona, Montgomery A Springfield
Weinstein, Chas L Kansas City
Weiss, Howard St Louis
Weiss, Stuart St Louis
White, Harry H Columbia
Wong, George F, III Springfield
Yanover, Robert A St. Charles
Youmans, Ronald A Kansas City
Yu, Mario K Kansas City
Zimmerman, Devin D Grover

NEP-NEPHROLOGY

Benson, Larry E No. Kansas City
Birenboim, Nancy Kansas City
Braxton, Frank W Cape Girardeau
Langley, Harriet S Kansas City
Mir, A. Rauf Kansas City
Nolph, Karl D Columbia
Thomas, Alexis G Kansas City
Winkelmeyer, William K Columbia
***Young, Michael A** Jefferson City

NM-NUCLEAR MEDICINE

Allego, Melquiadito M Perryville
Donati, Robert M St. Louis
Dukstein, Walter G, Jr. Shawnee Mission
Egbert, Robert N Springfield
Gotti, Edward W Springfield
Lilly, Douglas R St Louis
Long, Stephen E Springfield
Siegel, Barry A St. Louis
***Volarich, David T** St. Louis

NPM-NEONATAL-PERINATAL MEDICINE

Braun, William J Kansas City
***Hall, Frederick K** Overland Park
Kinney, Janet S Kansas City
Meyer, Bruce A Kansas City
Slack, Melinda R Springfield

NR-NUCLEAR RADIOLOGY

Hacker, Douglas A Springfield

NS-NEUROLOGICAL SURGERY

Albanna, Faisal J St. Louis
Backer, Robert J St. Louis
Bailey, Gregory J Chesterfield
Beatty, Robert M Kansas City
Bucholz, Richard D St. Louis
Canlas, Mario P Springfield
Chaudhari, A. Basit Cape Girardeau
Chilton, Jonathan D Kansas City
Clough, Chas A Kansas City
Cole, Harry O Chesterfield
Cova, Reno R Sikeston
Cox, Curtis S Jefferson City
Coxe, Wm S St Louis
Crabtree, H. Mark Springfield
Crafts, David St. Louis
Dacey, Ralph G, Jr. St. Louis
Daus, Arthur S Joplin
Ditmore, Q. Michael Columbia
Dunn, Robert C, Jr. St. Louis
Ferguson, John F Springfield
Gall, Clifford M Kansas City
Geise, August W Chesterfield
Gold, Jonathan A St. Louis
Goldring, Sidney St. Louis
Grubb, Robert L, Jr. St. Louis
Hanson, E J Kansas City
Hornig, Gregory W Kansas City
Jacob, Karl A St Louis
Kaufman, Andrew B Kansas City
Kaufman, Bruce A St. Louis
Kennedy, David G St. Louis
Ketcherside, W. Joseph Liberty
Kim, Yong Kie Cape Girardeau
Krettek, John E Chesterfield
Lattinville, Henry E Bridgeton
MacGee, Edwin E Kansas City
Majzoub, Hish S Joplin
Marchosky, J. Alex Chesterfield
Mendelsohn, George E Chesterfield
Mollman, H. Dennis Chesterfield
Mujica, Patricio H St. Joseph
Oro, John J Columbia
Orth, O. Gerald Columbia
Pardo, Leopoldo P St. Louis
Park, Bert E Springfield

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*Doctor of osteopathy.

Park, Tae S St. Louis
Picker, Selwyn St. Louis
Pittmann, Thomas St. Louis
Reintjes, Stephen L Kansas City
Rengachary, Setti S Kansas City
Rich, Keith M St. Louis
*__Routsong, Rodney T__ St. Louis
Schoolman, Arnold Kansas City
Scodary, Daniel J St. Louis
Smith, Kenneth R, Jr. St. Louis
Stepp, Timothy E Kansas City
Stohr, Paul E St. Charles
Vollmer, Dennis G St. Louis
Walker, Francis S St Louis
Walker, Gregory E Independence
Whitlock, C. Courtney Springfield
Whittaker, Chas K Kansas City
Wilkinson, David St Louis
Yoon, Kong-Woo St. Louis
Young, Paul H St. Louis

OBG-OBSTETRICS & GYNECOLOGY

Agasino, Gaudencio L Sullivan
Ahlering, Christopher L St. Louis
Ahlering, George P St. Louis
Ahlum, Sandra J Hannibal
Ahmad, Nusrat J Ballwin
Alderman, Lillian C Liberty
Anstey, Geo C St. Ann
Anstey, John T St. Ann
Appelbaum, John K St. Louis
Arias, Fernando St Louis
Azan, Abraham N Sedalia
Bagwe, Lata R St. Louis
Baldwin, Richard M Springfield
Bale, Robert D St. Louis
Barloon, James H Kansas City
Batts, Barbara A Kansas City
Beaty, Wm R St. Ann
Becker, Robt L St. Louis
Behrend, Ann E Kansas City
Belew, Joe E Chesterfield
Bell, Laird A Springfield
Benitez, Jose A St. Louis
Bennett, John St. Charles
Benson, Ronald G Springfield
Benton, Mary Beth Columbia
Bernabe, Florinio H St. Louis
Bever, Grant A Harrisonville
Bickley, James E Kansas City
Blaskiewicz, Robert J St. Louis
Blythe, James G St Louis
Boedeker, James P St. Louis
Bohon, Barbara D Kansas City
Bonebrake, Albert J Springfield
Bonebrake, Mac D Springfield
Bonfanti, Albert L St. Louis
Boone, Vicky L Springfield
Bopp, J. Ronald Joplin
Borello, Dan J Joplin
Botney, Kathryn Chesterfield
Boveri, Jos C St Louis
Boyd, Craig W St. Louis
Braby, Howard H Independence
Brennan, James M St. Louis
Brennan, Robert A, Jr. St. Louis
Brown, Cynthia L Poplar Bluff
Brown, Robert J St. Charles
Burks, Michael L Columbia
Burstein, Robert Richmond Hghts
Bury, Robert J Overland Park
Calbert, Cythia C Lee's Summit
Cancelada, Juan Farmington
Carr, David A Sikeston
Caruso, Alfred A Kansas City
Caruso, Peter J Leawood
Casey, Arthur L St. Louis
Cassels, John W, Jr. Columbia
Cernik, Christine M St. Louis
Chaudhuri, Sudha T Raytown
Chesney, John W Joplin
Chirino, Octavio R St. Louis
Chod, Ronald J Chesterfield
Clark, Larry K Joplin
Clayton, Bradford E St. Louis
Cohen, Robert S St. Louis
Comas, Manuel R St. Louis
Cooper, Robt L, II Warrensburg
Corder, Robt L St. Joseph
Cornwell, Karen R Kansas City
Coronado, Mario A St Louis
Coyne, Patrick M Florissant
Crane, James P St. Louis
Dagartzikas, A K St. Louis
Dahm, Chas H, Jr. St. Louis
Daly, James W Columbia
Datta, Narendar K Crystal City
Davidson, Raymond P St. Louis
Del Pizzo, Ferdinand St Charles
Dement, Oman E Joplin
Dent, George W Farmington
Denton, John L Jefferson City
DeUngria, Pablo C Bridgeton
Diemer, Kathryn M St. Louis
Dieterich, Russell B St. Charles
Dix, Patricia M Springfield
Doan, Laura B Raytown
Duello, Deborah K Lee's Summit
Dugger, David E St. Louis
Duncan, David T St. Peters
Dunn, Melanie A Independence
Durel, Justin H St. Louis
Eachempati, Uma R Arnold
Eaton, Paula Kansas City
Ekunno, Josiah O Florissant
Feldman, Mark R St. Charles
Ferber, Alan J Kansas City
Ferguson, John P Springfield
Ferneau, James E Columbia
Ferns, Francis E Kansas City
Ferris, Robert E Jefferson City
Fogle, Philip R Springfield
Fortin, Jorge A Rolla
Friesen, Randall G St. Charles
Galakatos, Andrew E Chesterfield
Gall, Ira C St. Louis
Gardner, Joe A Joplin
Garrison, David L St Joseph
Gay, John W Columbia
German, Walter A Springfield
Gimpelson, Richard J Chesterfield
Goeking, C Keith St. Joseph
Goerz, Royal D Independence
Goldman, Gordon M St. Louis
*__Gordon, Stephen M__ Kansas City
Gowen, Rose M St. Louis
Grace, Steve Springfield
Graves, Kathleen L Springfield
Gray, Diana L St.Louis
Grebe, T. Keith Joplin
Green, Thomas F Independence
*__Greenspan, Peter B__ Independence
Griffin, Wm T Columbia
Gulick, C. Richard St Louis
Gutknecht, Richard Independence
Hahn, Yoram Florissant
*__Hamilton, William V__ Lexington
Handler, Michael R St. Louis
Hanley, Thomas P St. Louis
Harms, Lawrence L St. Louis
Hartman, Richard A St. Louis
Hasik, Karl J St. Peters
Hauser, Robert J Jefferson City
Hayes, Kimberly W Independence
Hazan, Joseph Bridgeton
Heller, Randall L, Jr. St. Louis
Herzog, Godofredo M Florissant
Hickey, James L St. Louis
Higgins, Philip C St Louis
Hill, Randy C Springfield
Ho, Grinny H Sikeston
Hoja, John M Poplar Bluff
Hoja, W Alex Poplar Bluff
Houck, William E St. Louis
Hubbell, George P Osage Beach
Hulbert, Laura R St. Louis
Hunleth, Frank E St. Louis
Hurley, Martha L Blue Springs
Huse, William J, II Kansas City
Hustead, Russell M Shawnee Mission
Huster, Robert M Rolla
Ishida, Yasuo St Louis
Jackson, Darwin C Florissant
Jantsch, Deborah A Kansas City
Johnson, Jos C, Jr Springfield
Johnson, Michael K St. Louis
Johnson, Rebecca S Kansas City
Jones, Jeffrey T Joplin
Jones, Michael D Mexico
Kaufmann, Herbert H Kansas City
Keay, Myoung Soo Chillicothe
Kelly, John B Joplin
Keltner, Raymond O Kansas City
Kessel, James W St Louis
Kim, Yang H Washington

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*Doctor of osteopathy.

Kline, James St. Joseph
Kobbermann, Kobby J Springfield
Kobbermann, Thomas W Liberty
Kovac, S. Robert St Louis
Kraner, Justin F St. Louis
Kumari, Vijaya St. Louis
Kuo, Gong T Kennett
Lamping, J. Daniels St. Louis
Lim, Piemsak Bridgeton
Lin, C H Moberly
Lintecum, Frederick B Kansas City
***Little, Patrick T** Hayti
Liu, Ben C Kansas City
Llorens, Alfred S Columbia
Lockwood, Gary F Kansas City
Madduri, Aruna D Poplar Bluff
***Magill, William S** Springfield
Maitz, Carlos A St. Ann
Maminta-Streiff, Maria G St. Louis
Marshall, William H Jefferson City
Marston, F. James St Joseph
Martin, Daniel J St. Louis
Mathew, Ruby Chesterfield
Matile, Gerald U Kansas City
Maupin, Kathy C Florissant
Maxson, Katherine A Chesterfield
Maynard, Colleen M Kansas City
McCorcle, Marcus D Springfield
McDavid, Robert E Columbia
McGuire, Thomas H Shawnee Mission
McLaughlin, Richard D Springfield
Medler, John F St Louis
Meiners, Theodore M Chesterfield
Middleton, Jerry N Chesterfield
Miller, Gerald L, Jr. Kansas City
Mistry, Tehmton S Chesterfield
Moeller, F. Delbert Lake St. Louis
Monterubio, Fred R, Jr. St. Louis
Mooney-Smith, Patricia Kansas City
Mora, Alvaro Bridgeton
Morley, Mary A Chesterfield
Morris, Terry V Independence
Mou, Susan M Kansas City
Muckerman, Richard C, II St. Louis
Muckerman, Richard I St. Louis
Murdock, Nathaniel St. Louis
Myers, Ivan T St. Louis
Nagy, Rickey E Kansas City
Newport, Gerald Florissant
Nickell, Margaret B Kansas City
Nouhan, Joseph G, Jr. St. Louis
Nouri, Hassan St Louis
Ong, Ofelia S St. Louis
Ostapowicz, Tamara L St. Louis
Ott, Harold J St Louis
Ott, William J St. Louis
Otto, William J Springfield
Padilla, Teresita C Chesterfield
***Palmer, Allen S** Bridgeton
Patty, Carl F Poplar Bluff
***Patty, John R** Poplar Bluff
Pearce, Eugene W Kansas City
Pearse, Carlton S Chesterfield
Pearson, William E St. Louis
Penney, Larry L Columbia
Perez, Raul E St. Louis
Pignotti, Blase J St. Louis
Poole, Anthony G Sikeston
Potts, Gregory A Washington
Powell, Lisa G Springfield
Pringle, Scot G Cape Girardeau
Probst, James R St. Louis
Probst, Raymond E St Louis
Pyeatte, Jacob P, Jr. Cape Girardeau
Raksakulthai, Vinai Fredericktown
Rappold, Henry O Chesterfield
Rawlins, Fred E Cape Girardeau
Redfern, David L Springfield
Rengachary, Dhanalakshmi Kansas City
Rennard, Marvin St. Louis
Riley, Louis T Chesterfield
Ritter, Hubert A St. Louis
Robinson, Gary L Springfield
Robinson, Van M Marshall
***Roitman, Martin J** Bridgeton
Roter, Alexander M St Charles
Rusterholz, Joyce E Middletown
Sachar, Jerome D St. Louis
Saha, Sudha R St. Louis
***Saleh, George A** Kansas City
Salinas, Mario St. Louis
Saneman, Paul P Joplin
Santos, Divina J St. Louis
Sauvage, Jacques P St Louis
Schaberg, Kevin B Chesterfield
Schillie, Gene A Kansas City
Schuetz, Evelyne G St. Charles
Schwartz, Howard I Kansas City
Schwartz, Melvin M St. Louis
Seeck, Linda E Washington
Shanahan, Mary P Joplin
Shaner, Thomas P St Louis
Shelton, Becky R Chesterfield
Shultz, Thomas M Springfield
Siripipat, Pallop Mexico
Slankard, J E Kansas City
Smiley, William L St. Louis
Smith, Brenda S Kansas City
Snidle, William F Crystal City
Snowden, Kent L St. Louis
Sopuch, John A St. Ann
Sowash, James J Columbia
Spradlin, Larry D Kansas City
Starks, Gregory C Kansas City
Steiman, Barry Creve Coeur
Stewart, Ronald M Kansas City
Stockwood, Robt C Sedalia
Stone, Mary K Blue Springs
Stribling, Thos L Independence
Strobach, Kurt F St. Louis
Stuppy, Mark S Springfield
Su, Philo S Jefferson City
Sullivan, Bradley H Kansas City
Sunderji, Shiraz St. Louis
Taute, Hermann St. Louis
Taylor, Eugene D St. Louis
Tendai, Mark M Springfield
Thompson, M. Bryant Chesterfield
Thorp, James A Kansas City
Tissier, Bradley J St. Ann
Tobey, Albro C, Jr. St. Louis
Tobler, Randall W St. Louis
Trammell, Lee W Columbia
Triplett, Daniel A Liberty
Turano, Wm L Raytown
Tutera, Gino Kansas City
Vajaranant, Manit Lexington
Van Dyke, Elmer H Sedalia
Vierling, Timothy E Moberly
Villamar, Elizabeth N St. Louis
Vivian, Gary D St. Peters
Walker, Gary K Springfield
Walker, J Leslie St. Louis
Walker, William M Springfield
Wallace, Darryl L Kansas City
Walley, Lynn J Hannibal
Walsh, Barbara A St. Louis
Wasserman, Gary M St. Louis
Wasserman, Mark S St. Louis
Watts, Larry K St. Joseph
Weinstein, David L St. Louis
Wheeler, Paul D Liberty
White, Eugene F Rolla
Whitten, J S Cape Girardeau
Wilbois, Ronald P St Louis
Williams, Fred Columbia
Williams, John W, IV Springfield
Winer, Herbert J Kansas City
Wright, Andy J Springfield
Wyrsch, Leo M Springfield
Yang, John S Ste. Genevieve
Yannakakis, John E Florissant
Yarwood, Robert L Lake St. Louis
Yazdi, Tom M Crestwood
Yeast, John D Kansas City
Yoon, Jin S Chillicothe
Youngblood, James P Kansas City

OM-OCCUPATIONAL MEDICINE

Bailey, Marsha L Arnold
Balster, Vernon H St. Louis
Beeks, John W Kansas City
Brothers, Mary E Kansas City
Del Rosario, Horacio O Chesterfield
Engelberg, Alan L St. Louis
Hardy, John W Kansas City
Hedges, Richard C Kansas City
Hughes, Robt G St. Louis
Kagan, Stuart M Shawnee Mission
Kopp, Shelby K St. Louis
Meadows, C. Douglas St Louis
Patel, Ashokkumar B St. Louis
Skeins, Edward J, Jr. Springfield
Vale, Janie R Columbia

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*Doctor of osteopathy.

Welter, Eugene S Kansas City

ON-ONCOLOGY

Albritton, Michael A Springfield
Bedwinek, John M St. Louis
Carolla, Robert L Springfield
Chapman, Ramona Marie Joplin
Clouse, John W Springfield
Cox, W. Welby Springfield
Crosby, William H Joplin
Cunningham, William F Springfield
Davis, Mary Margaret Jefferson City
Garcia, Delia M Chesterfield
Hasler, Galen R Springfield
Hoos, Gary L Springfield
Laguerre, Max S N. Kansas City
Lee, Fransiska A St. Louis
Matthews, Richard H Rolla
Miller, Joseph P Jackson
Mitchell, Edith P Columbia
Myers, Duane E Joplin
Myron, Mark C Kansas City
Pendergrass, Kelly B Kansas City
Perry, Michael C Columbia
Raju, Padma I Altoona
Skelley, Mark J Joplin
***Stillie, G. Donald** Kansas City
Syzek, Elizabeth J Columbia
Trowbridge, Denise R Olathe
Walls, Earlene H Kansas City

OPH-OPHTHALMOLOGY

Amin, Navin J St Louis
Arnold, Paul N Springfield
Arribas, Neva P St Louis
Assil, Kerry K St. Louis
Avins, Laurence R St. Louis
Bass, Walter R Raytown
Bauman, Alan E Kansas City
Becker, Bernard St. Louis
Becker, Rolfe A Kansas City
Becker, Stanley C St Louis
Becker, William L Kirkwood
Benedett, Robert E Springfield
Berdy, Gregg J Creve Coeur
Berg, Edward F St. Louis
Bilchik, Ronald C Chesterfield
Black, Thomas C, Jr. Kansas City
Blinder, Kevin J Columbia
Bloom, Jeffrey N St. Louis
Bobrow, James C St Louis
Bohigian, George M St. Louis
Bonham, Roger D Columbia
Boniuk, Isaac St. Louis
Bourjolly, Wilson P Florissant
Bowen, Stephen F, Jr. St Louis
Bradford, John F Kansas City
Brady, Harry R St Louis
Brigham, David W Ballwin
Bruce, Leo A Sikeston
Burgess, Dean St Louis
Byars, Steven R Kansas City
Canaan, Samuel A, Jr. St Louis
Case, Wm F Kansas City
Catanzaro, Frank J, Jr. St. Louis
Cavanaugh, Timothy B Kansas City
Chavala, Sudarsan Maryville
Cheek, Chas W Columbia
Chipongian, Raul A St. Louis
Chishti, M. Ishaq St. Louis
Chu, Fred C Chesterfield
Chung, Sophia M St. Louis
Cibis, Gerhard W Kansas City
Clever, Victor G St Charles
Cohen, Bruce H St. Louis
Colon, Luis E St. Louis
Cook, Jerry W Kansas City
Couch, Jeffrey M No Kansas City
Cozean, Charles H Cape Girardeau
Crapotta, Joseph A St. Louis
Cundiff, H. Clay Independence
Curran, Terrence Kansas City
Custer, Philip L St. Louis
Davisson, Walter F Jefferson City
Dehning, Doug O Independence
Del Priore, Lucian V St.Louis
Deligeorges, John Kansas City
Dixon, Herbert K Joplin
Drews, Robt C St Louis
Dueker, David K Columbia
Durrie, Daniel S Kansas City
Eggleston, Harry C St Louis
Eggleston, Thomas F St Louis
Ellis, Jean H Blue Springs
Escoffery, Richard F Florissant
Fitz, John R Farmington
Fivian, Gerald J St Louis
Fleming, Robt J St Charles
Fletcher, Robert C Kansas City
Ford, Thomas E Niagara Falls
Fouraker, Bradley D Tampa
Frank, Bruce S St. Charles
Gabel, Michael G St. Louis
Gans, Lawrence A Florissant
Gessler, James A Springfield
Giangiacomo, Joseph Columbia
Goldstein, Marvin F Kansas City
Goltschman, John P Florissant
Goodrich, Steven D St. Louis
Gordon, James M Florissant
Grand, M. Gilbert St. Louis
Green, Morton R Belleville
Hagan, John C, III No Kansas City
Hart, William M, Jr. St Louis
Hartstein, Jack Chesterfield
Harvey, Judith E Springfield
Holds, John B St. Louis
Holekamp, Timothy Columbia
Horton, Bill G Springfield
Hunkeler, John D Kansas City
Huq, MD N Mexico
Hyde, Lawrence L Kansas City
Johnson, Lenworth N Columbia
Jones, Robert W West Plains
***Jordan, Earl L, Jr** Joplin
Jung, J. Marshall Cape Girardeau
Kamenetzky, Stephen A St. Louis
Kaplan, Henry J St. Louis
Kass, Michael A St. Louis
Kayes, Jack St Louis
Kenneally, Cynthia Z St. Louis
Kies, Richard L Cape Girardeau
Knopf, Harry L St. Louis
Koenig, Marvin I St. Louis
Kolker, Allan E St. Louis
Kretchmar, Alan P St Louis
Krummenacher, Thomas K St. Louis
Landhuis, Leo R Columbia
Lederer, Charles M, Jr. Kansas City
Lee, King Y Kansas City
Leibsohn, Joel M Independence
Lentz, Kathy J Washington
Levenson, Ernest Poplar Bluff
Lewin, W. Howard St. Louis
Lewis, Matthew T Jefferson City
Lewis, Robert D St. Louis
Linde, John W Rolla
Lubniewski, Anthony J St. Louis
Manuel, Louis C Kansas City
Matta, Camille S Kansas City
Mattax, James B, Jr. Springfield
McCabe, Eugene J St. Charles
McGonigle, James P Joplin
McKnight, Scott J Liberty
McLaughlin, Durnell Kansas City
Mehlhorn, Gary L Springfield
Meredith, William R Joplin
Meyer, Melvin E St Louis
Michaels, Robert H Springfield
Milder, Barry D St. Louis
Miller, James E St. Louis
Morey, Kirk P St. Louis
Morgan, Stephan S St. Louis
Morrison, Tom V Branson
Murphy, James A St Joseph
Neu, Leo T, III Springfield
Newman, Matthew St. Louis
O'Donnell, Francis E St. Louis
Olk, R. Joseph St. Louis
Olson, E. Rule Springfield
Ott, F. Thomas St. Louis
Parelman, Allen G Kansas City
Parelman, Joseph J Kansas City
Pepose, Jay S St. Louis
Perlmutter, John C St. Charles
Pernoud, Flavius G, III St. Louis
Pernoud, Joan M St. Louis
Peterson, Craig A Springfield
Piebenga, Larry W Kansas City
Place, Kenneth C Kansas City
Plowman, Edward M Hannibal
Pojanasomboon, Pichat Rolla
Prater, Bill G Springfield
Prater, Thomas G Springfield

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*Doctor of osteopathy.

Price, Patrick K Fairway
Purcell, John J, Jr. St Louis
Rahman, Moududur St Louis
Reddy, Nalini A West Plains
Rednam, Krishnarao V Kirkwood
Revels, Harry , III Leawood
Ridgeway, Wm G St. Louis
Ringer, C. Nelson Cape Girardeau
Roedel, Kathryn R Sedalia
Rosenthal, William N Kansas City
Sabates, Felix N Kansas City
Sabates, Roland Kansas City
Salmon, M. L. St. Louis
Samudrala, Ramulu St. Louis
Schanzlin, David J St. Louis
Schoch, Lawrence H Florissant
Schoengarth, Lowell D Columbia
Scott, Wendell J Springfield
Shah, Anwar St. Louis
Shah, Ramesh R Joplin
Shelton, R. Wayne Springfield
Sherrod, Charles F Joplin
Short, Howard N Washington
Sigmund, Charles A Bridgeton
Silver, Bernd St Louis
Silverstein, Steven M Independence
Slocum, Stephen G St. Louis
Smith, C. Byron , III Kansas City
Smith, Morton E St. Louis
Smith, Porter Kennett
Somers, Michael E N. Kansas City
Spalding, David L Springfield
Spalding, Wilber B, Jr. Kansas City
Spurrier, Mark H St. Louis
Stafford, Walter R St. Louis
Stauffer, Larry K Jefferson City
Stewart, L. Paul St. Louis
Stickle, Arthur W St. Louis
Stiles, Michael C Kansas City
Stout, Carl N Independence
Taylor, John R.W. Kansas City
Tekwani, Hiralal T St Louis
Tess, Allen F Florissant
Thomas, Matthew A St. Louis
Tobin, Robert F St Joseph
Traxel, Wm L Poplar Bluff
Tyler, Thomas D Lexington
Walter, William L St Louis
Waltman, Stephen R St. Louis
Wankum, Robert P Jefferson City
Watson, Richard A St. Joseph
Wax, Martin B St. Louis
Weir, Robt K Kansas City
Westrich, David J Cape Girardeau
Wexler, Stephen A St. Louis
Wurster, Jerry B Kansas City
Yang, H. Kell Columbia
Yoselevsky, Robert St. Louis
Young, Thomas J St Joseph
Yuhas, John A Joplin
Ziemianski, Matthew C Kansas City

ORS-ORTHOPEDIC SURGERY

Abernathie, Dennis L Columbia
Adams, Allen G St. Louis
Adams, Mark A Columbia
Adler, Federico Kansas City
Albus, Thomas E Bridgeton
Allen, William Corwin Columbia
Andersen, David A St. Louis
Anderson, David J St. Louis
Arnot, John P St Louis
Ash, Charles J Springfield
Aubuchon, Craig E St. Louis
Baldwin, Richard , Jr. St. Louis
Ball, David A Joplin
Banton, Thomas J Florissant
Barnard, John L, Jr. Kansas City
Barnthouse, Cris D Kansas City
Bassman, Donald R St. Louis
Beall, McPherson S, Jr. Kansas City
Beckett, Wm. Wilson Columbia
Belew, Mark Florissant
Bennett, Robert U Springfield
Benson, William F Kansas City
Benz, Stephen M St. Louis
Bernhardt, Mark Kansas City
Black, David L Joplin
Blair, Vilray P, III St. Louis
Bohn, William W Kansas City
Boylan, Peter C Kansas City
Brancato, Donald H St Louis
Brennan, Richard J St. Joseph
Britt, Cornelius L Crystal City
Brown, David W Springfield
Browne, Jon E Kansas City
Bruce, Robert P Kansas City
Buchert, Peter K Columbia
Burdge, Robert E St. Louis
Burleigh, Bruce W Joplin
Burns, Michael F St. Louis
***Cameron, Roger W** Jefferson City
Carroll, Danny K Belton
Carter, Edwin E St. Louis
Carter, Ronald D Columbia
Chan, Kwan-Ho "Casey" Joplin
Cho, Kyu S St Louis
Clarke, Michael S Springfield
Collins, John W Independence
Cordell, Larry D Kansas City
Costen, William S Chesterfield
Couchman, Ryan W Kirkwood
Cunningham, R. Raymond Columbia
Curnow, Richard B Liberty
Darnell, Dale E Kansas City
Davis, Leonard L Mexico
Dillard, Erin M Springfield
DiFilippo, Emil A St Charles
Doerr, Dale E St. Louis
Drisko, Robert M, II Kansas City
Dubin, Sol H Independence
Dugan, Gerald F Kansas City
Duncan, Douglas M Springfield
Dusek, Dennis A St. Louis
Ebelke, David K N Kansas City
Eckenrode, James F Columbia
Edwards, Ryan K Sedalia
Eller, Gordon W Cape Girardeau
Ellfeldt, Howard J Kansas City
Ellsasser, James C Rocheport
Emanuel, James P St. Louis
Esch, John G Joplin
Evans, Lawrence G, Jr. St Louis
Fox, Thomas J St. Louis
Frank, Gael R No Kansas City
Frevert, Larry F Kansas City
Frewin, Paul R Springfield
Frumson, Guy H Florissant
Gaines, Robert W Columbia
Gainor, Barry J Columbia
George, Philip G St Louis
Gilden, Jerome J St. Louis
Glaser, Larry F Cleveland
Gondring, William H St Joseph
Grant, William T St. Louis
Gurba, Danny M Kansas City
Haas, Robert W Liberty
Hamilton, Dennison R Shawnee Mission
Hammond, D. Wade St. Louis
Harmon, Ben C Springfield
Harris, Hugh G Springfield
Harris, Lanny W Kansas City
Haupt, Herbert A St. Louis
Havey, John Columbia
Hernandez, Salvador R St. Louis
Hertel, Ronald C St. Louis
Highland, Thomas R Columbia
Hoffmann, Ronald E St. Louis
Holand, Roy W Springfield
Holder, Barrett K St. Louis
Hollocher, Richard J St. Louis
Hood, Roger W Shawnee Mission
Hufft, Robert E, Jr Springfield
Humphreys, William St. Joseph
***Hunter, Harlen C** Chesterfield
Jackson, Roger P Kansas City
Jeffries, Joel T Columbia
Jelley, V. Carl Blue Springs
Johnson, Glen E St. Louis
Johnston, Richard St. Louis
Jolly, Ben L Mexico
Jones, Bruce N Chesterfield
Jones, Lowry , Jr. Kansas City
Jones, Robert P Blue Springs
Joyce, Steven T Kansas City
Kenney, John D St. Louis
Keohane, Mark St Charles
Kiburz, Douglas W Sedalia
Kramer, Robert S St. Louis
Krautmann, John J Jefferson City
Kriegshauser, Lawrence A St. Louis
Kuhlman, Robert E St Louis

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*Doctor of osteopathy.

Lange, David R Bridgeton
Lansche, W. Edward St. Louis
Lehman, Richard C St. Louis
Lents, Rickey L Cape Girardeau
Leslie, James T Jefferson City
Linsenmeyer, Charles M St Charles
Littlejohn, Robert T N Kansas City
Lord, Richard E St. Louis
Loth, Timothy S St. Louis
Luechtefeld, Frank Florissant
Luther, George A St Louis
Mahnken, Robert F Springfield
Mannis, Charles I St Louis
Manske, Paul R St. Louis
Mardjetko, Steven M St. Louis
Marti, Larry B Rolla
Martin, Jeffrey W Bridgeton
Maylack, Fallon H Florissant
McElroy, Glenn L Columbia
McMillin, John N Springfield
McMullin, Forbes A St Louis
McMurray, Scott W Springfield
McQueary, Frederick G Springfield
Mell, Roger L Chesterfield
Merenda, Frank J St. Louis
Merenda, James T St. Louis
Merkel, Kurt D St. Louis
Miller, Harry G Clinton
Mirbaha, Mitchell M St. Louis
Mishkin, Marvin R St Louis
Morris, Alan H St Louis
Morse, John P Kennett
Mueller, Adolph R Joplin
Nachtigal, Michael P Springfield
Neighbor, Ernest H Kansas City
O'Meara, Clifton B Sedalia
Olive, Paul M Springfield
Otten, Joseph V Bridgeton
Parkins, George K Kansas City
Parsons, Clyde W, III Springfield
Pawsat, John E Kansas City
Petkovich, Frank O St. Louis
Phillips, John J Florissant
Phillips, Thomas P Kansas City
Piontek, Jerome G Chesterfield
Pomphrey, Martin M, Jr. St. Louis
Porubsky, Gary L No. Kansas City
Prostic, Edward J Kansas City
Putnam, John L Springfield
Rao, Aswath N St. Louis
Rhoades, Charles E Kansas City
Rich, Margaret M St. Louis
Ritter, Ray A, Jr Cape Girardeau
Rogers, David B Springfield
Roush, Randall D Florissant
Russell, Garth S Columbia
Ryan, Thomas J Jefferson City
Samson, Barry L St. Louis
Sanchez, Jon J Springfield
Sandow, Theodore L Kansas City
Satterlee, C. Craig Kansas City
Schaberg, James E St. Charles
Scherr, David D Jefferson City
Schlafly, Bruce S St. Louis
Schlafly, Edward F, Jr. Chesterfield
Schlehr, Frank J Kansas City
Schmidt, Thomas L Kansas City
Schoenecker, Perry L St. Louis
Scott, Andrew Kansas City
Seagrave, Richard A Springfield
Sedgwick, William G St. Louis
Sertl, George O St Louis
Shaeffer, James T Springfield
Sheridan, John J St Louis
Shitut, Ravindra V St. Louis
Shively, Robert A St. Louis
Sicat, Alfonso V Warrensburg
Skimming, W. Lee St. Louis
Smith, Bruce D St. Joseph
***Smith, C. Daniel** St. Joseph
Smith, Kenneth R West Plains
Smith, Patrick A Columbia
Spencer, Donald M Kansas City
Stavrides, Pete D St. Louis
Steinberger, Robert Rocky Mount
Stitt, Ronald W, Jr. Kansas City
Stokes, Douglas L St. Joseph
Strecker, William B St. Louis
Strickland, James C St. Louis
***Stringer, Robert F** Joplin
Stronsky, David St. Louis
Stuckmeyer, James A Blue Springs
Sudekum, Joseph M St Louis
Sundstrom, Frank D Springfield
Susi, Jesse G St. Louis
Sutherland, Charles J St. Louis
Swaim, Truett Blue Springs
Takacs, Robert J Kansas City
Tatkow, Robert W St Louis
Tayob, Anver A St. Louis
Tessier, John E St. Louis
***Thomas-Richards, Jose R** Kansas City
Thorpe, William P Cape Girardeau
Tillema, David A Kansas City
Trecha, Randal R Columbia
Trueblood, Michael C Cape Girardeau
Tucker, Robert E St. Louis
Turnbaugh, Thomas R Jefferson City
Van Ryn, Jacques S Bridgeton
Vierling, Stephen E St. Louis
Vilmer, Charles E No. Kansas City
Vilmer, Stephen E N. Kansas City
Wagner, John R St Louis
Wakeman, Newt , Jr Springfield
Walentynowicz, James E St. Louis
Wayne, Sherwyn J St. Louis
Weise, Marc W St. Louis
Welke, Gordon A Poplar Bluff
Weltmer, John B, Jr. St. Louis
West, Harold D Independence
Weygandt, Paul L, Jr. West Plains
Whitaker, James H Kansas City
White, Newton B St Louis
Whiteside, Leo A Bridgeton
Williams, Joseph St.louis
Winer, Michael H St Louis
Wittgen, Edward M St. Louis
Wolf, Marion L Springfield
Yost, John G, JR Kansas City
Zehnder, Kenneth W St. Louis

OS-OTHER

Mongan, James J Kansas City
Rotskoff, Kenneth S St. Louis

OTO-OTOLARYNGOLOGY

Ailor, Edgar I Columbia
Barnhill, Floyd R Springfield
Benecke, James E, Jr. St. Louis
Berkowitz, Wallace P St. Louis
Bonacorsi, John Bridgeton
Boyd, James H St. Louis
Branham, Gregory H St. Louis
Buchwach, Kenneth A Independence
Burkey, Jordan W Springfield
Burroughs, Nathan D No Kansas City
Campbell, Gregory S Columbia
Christiansen, Sidney G St. Joseph
Conoyer, J. Michael St. Peters
Cook, Paul R Columbia
Cotton, Thos R Kansas City
Craig, Robert D Carmel
Davis, Sheldon Florissant
Davis, Wm E Columbia
Denninghoff, James S Columbia
Devine, Mark W N Kansas City
Dlabal, Luke J, Jr. Independence
Donovan, Thomas J St Louis
Druck, Norman S Chesterfield
Ehlert, Tamara K St. Louis
Ellis, John C Independence
Estrem, Scott A Columbia
Felker, C. Edward , III Sikeston
Freeman, Jerry C Kansas City
Friedman, William H St. Louis
Gates, George A St. Louis
Gladney, John H St Louis
Goebel, Joel A St. Louis
Guastello, Joseph R Kansas City
Guastello, Mario J Kansas City
Hahn, Frederick W Independence
Hantz, Oscar Florissant
Hayden, Richard E St. Louis
Herzog, Jacques A Chesterfield
Hughes, Michael F Kansas City
Ingram, Donald R Crystal City
Ippensen, John H Springfield
Jones, Timothy R St. Louis
Jung, Christopher H Cape Girardeau
Katsantonis, George St. Louis
Kendall, Forrest H Kansas City
King, Dana M, III St. Joseph
Kletzker, George R St. Louis
Knudson, Dennis R Columbia

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*Doctor of osteopathy.

Krebs, Festus J, III Kansas City
Kroeger, Geo B, Jr. St. Louis
Lampros, William P St. Louis
LaFerriere, Keith A Springfield
Levine, Laurence A St. Charles
Lewis, David M Sikeston
Lima, Jose A St. Louis
Loynd, Robt C St. Louis
Luetje, Charles M Kansas City
Lyman, Edward H Clayton
Mangum, William B Independence
Marchiando, Albert W Washington
Martin, Richard A Cape Girardeau
Marty, David R Jefferson City
Maslan, Mark J Kansas City
Maves, Michael D St. Louis
McGonigle, Michael M Joplin
McKinney, John W St. Louis
Mechlin, David C Columbia
Mertz, Janet S Kansas City
Moranz, John W Van Buren
Moritz, Gerald Bridgeton
Pavlovich, Andrew S Independence
Phanijphand, Suwan Poplar Bluff
Price, Richard B Kansas City
Rea, James L Jefferson City
Reichert, Timothy J St. Louis
Renner, Gregory J Columbia
Roberts, Perry T Cape Girardeau
Robinett, Wade V Kansas City
Rogers, Robt L Kansas City
Roh, Lynn H Kansas City
Rosenblum, Barry N St. Louis
Rothweiler, Robert J St. Louis
Saxon, Keith G Liberty
Schrick, Richard E St. Louis
Schroeder, Walter A, Jr. Cape Girardeau
Seiden, Gerald D Kansas City
Sessions, Donald G St. Louis
Shagets, Frank W Joplin
Simo, Frank St. Louis
Singleton, Marvin A Joplin
Smith, Peter G St. Louis
Snow, Jon F Springfield
Spake, R. Vanneman Kansas City
Spector, Gershon St Louis
Stroble, Mark St. Louis
Templer, Jerry W Columbia
Thawley, Stanley E St Louis
Thedinger, Bradley S Kansas City
Thomas, Robert M Columbia
Tumanut, Benesto F Gladstone
Viers, Wayne A St Louis
Vighi, James R St Charles
Waxman, Joel E Springfield
West, Joseph W St. Louis
Wible, Jerry C Springfield
Wild, Alan P. K. Chesterfield
Williams, Roland D Kansas City
Willman, Martin L St Charles
Wolfe, James B Springfield
Wurster, W J Kansas City
Yates, Karen Cape Girardeau
Zitsch, Robert P, III Columbia

P-PSYCHIATRY

Abichandani, Lachman K Chesterfield
Ajans, Zaki A Mexico
Aleksander, Bernardo G El Paso
Allison, James B Springfield
Anderson, Thos R Columbia
Arbaugh, Scott J Florissant
Baird, Keim L St. Charles
Balcer, Charlotte M Jefferson City
Bandle, Donald F St. Louis
Banez, Colita R St. Louis
Bartulica, Nicholas St Joseph
Beitman, Bernard D Columbia
Berland, David I St. Louis
Biggs, John St Louis
Bird, H. Waldo , Jr. St Louis
Bright, James E Springfield
Bronson, Shael S St Louis
Brookes, Robt D Chesterfield
Cabanas, Justo J Shawnee Mission
Calabria, Rafael Nevada
Calhoun, Joshua W St. Louis
Callaway, Jo J Kansas City
Canale, John P St. Charles
Childs, Richard M Kansas City
Choi, Sei Young St. Charles
Christy, Richard R Springfield
Clary, Wm F Springfield
Cloninger, C. Robert St. Louis
Cole, Sherman W Kansas City
Corday, Robt J St. Louis
Corvalan, Juan C St Louis
Cox, John P Amazonia
Crane, John B Washington
Croughan, Jack L St. Louis
Crumpacker, Margaret St. Louis
***Curran, Donald J** Rolla
Curry, Denise T St. Louis
Daskalov, Zhivko Kansas City
Davis, Mary A St. Louis
Day, Chester L Prairie Village
Decanini, Mario St Joseph
Del Valle, Fernando Chesterfield
Dewald, Paul A St Louis
Dewein, Edward G St Louis
Dick, Earl Columbia
Dick, M. Marga Ashland
Dowell, Geo H St Louis
Edmisten, Jack Nevada
Eikermann, William C Kansas City
Ericsson, Saml E Kansas City
Farzana, Farida St. Louis
Favazza, Armando R Columbia
Finn, Murray E St Louis
Frazier, Robt E Columbia
Fuller, Terry A St. Louis
Gadson, Michael T Quincy
Gagliardo, Joseph St. Louis
Garcia, Eduardo L St. Louis
Gavankar, Sharad S Joplin
Glazzard, Charles D Springfield
Glenn, Theodore J Cape Girardeau
Gonzalez, Alicia D St. Louis
Greenfield, Jerome F Jefferson City
Grossberg, George T St. Louis
Guindon, Kurt R Columbia
Guze, Samuel B St. Louis
Hagen, Duane Q St Louis
Harrison, Richard L St. Louis
Hartnett, Anna E St. Louis
Hartnett, Thomas D St Louis
Heimburger, Elizabeth M Columbia
Hicks, Frederick G St. Louis
Hicks, Robert S St. Louis
Holemon, R. Eugene St. Louis
Hornstra, Robijn K Kansas City
Houghton, Howard L Kansas City
Hudgens, Richard W St. Louis
Hughes, Derek Columbia
Hulstra, Johannes F Springfield
Irvin, Wm M St Louis
***Jacks, Richard K** St. Joseph
Jatala, Ijaz A Granite City
Jones, Georgia A St. Louis
Jones, Laird E Springfield
Kamath, K.P.S. Cape Girardeau
Kaplan, Alex H St Louis
Katf, Nicola Y N. Kansas City
Khojasteh, Saaid St. Louis
Kitchen, Alice D St. Louis
Kleinschmidt, Donn C St. Louis
Knowles, R. Raymond Webster Groves
Kreisman, Jerold J St. Louis
Krojanker, David N St. Louis
Krojanker, Rolf J St Louis
Kuhn, Lawrence F St. Louis
Kulak, Gary St Louis
Kulkarni, Satish R Town & Country
Lamb, Wanda St. Louis
Lamberti, Jos W Columbia
Laramore, Rosemary Columbia
***Lensgraf, S. Jay** Sedalia
LeFevre, Philip J Springfield
Lindgren, Carleton J Independence
Lipschitz, Ervin St Louis
Liss, Jay L St Louis
Lucas, Thomas G St. Louis
Malmberg, Virgil L Chesterfield
Mangunta, Vijaya K New Madrid
McAfee, Gordon Springfield
McKnelly, Wm V, Jr. Kansas City
Mendez, Maria A Springfield
Meyer, Harry E St. Louis
Meyer, Jay St. Louis
Meyers, Robert W St. Louis
Milgram, Byron A Kansas City
Miller, Jule P St Louis

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*Doctor of osteopathy.

Mittleman, Frederick S Prairie Village
Monroe, C. Dean Columbia
Moran, Thos M St Louis
Moritz, K. Lynne St. Louis
Munro, John S Kansas City
Nakra, Bharat Raj St. Louis
Nakra, Rashmi R St. Louis
Navato, Jose R Independence
Neal, James G Springfield
Nieuwenhuizen, Maarten Columbia
Nowotny, Thomas J St. Louis
O'Neal, Patricia L St Louis
Ohlms, David L St Louis
Othmer, Ekkehard Kansas City
Packman, Paul St Louis
Parwatikar, Sadashiv D St Louis
Pew, Becky A St. Louis
Pickens, Andrew T St. Louis
Pompushko, Rosalie Kansas City
Post, Stephen L St Louis
Pro, John D Kansas City
Prochaska, Mark L Overland Park
Quiason, Arturo G Independence
Quick, Richard T St Louis
Rasmussen, Keith G St. Louis
Ratnam, Dasari V Kansas City
Reddy, Agara S Columbia
Reynolds, Robert B, Sr. Chesterfield
Ricci, Walter F Kansas City
Richardson, Thomas F St Louis
Rohatgi, Reeta Cape Girardeau
Rosenthal, Randall St. Louis
Rutherford, James L St. Louis
Ryall, Jo-Ellyn M St. Louis
Sabet, Abdollah A Ballwin
Saghir, Marcel T St Louis
Sata, Lindbergh S St. Louis
Schmitz, John M Kansas City
Seed, John C St Louis
Segraves, Steven D Kansas City
Selhorst, John B St. Louis
Shah, Modaser St. Louis
Shapero, James A Columbia
Sheffner, Paul W St. Louis
Shen, Winston W St. Louis
Siddiqui, Farzanna Q Woodriver
Simmons, Donald D Kansas City
Simon, Nathan M St. Louis
***Simpson, Floyd D** Springfield
Sitzman, Everette T Kansas City
Sletten, Ivan W St Louis
Smith, Dermott A St. Louis
Smith, James B St. Louis
Snow, Emasue Springfield
Soltys, Stephen M Columbia
Sommer, Conrad S St. Louis
Soorya, Narendir T St. Louis
Soto, Albert A St. Louis
Stewart, Harry A Kansas City
Stillings, Wayne A St. Louis
Suarez-Solar, Pedro L St Charles
Sumer, Cengiz M Bridgeton
Sundermann, Richard H St. Louis
Tenorio, Genoveva Albany
Tilzer, Seth Florissant
True, James D N. Kansas City
Trugly, Edith S St. Louis
Vafi, Houshang St Louis
Valera, Salvador S St. Joseph
Valtierra, Cesar A Clayton
Vandivort, Paul M, Jr. St. Louis
Vera, Enrique Kansas City
Viamontes, Jorge A St Louis
Vickar, Garry M Florissant
Wade, Larry A Springfield
Waite, John G St Louis
Wehrman, Stephanie A Chesterfield
Whitehead, Clay C St. Joseph
***Williams, Robert J** St. Joseph
Wilson, Roy E Springfield
Wolff, Harold D St. Louis
Wolff, Ray J St. Louis
Wolfgram, Edwin D St Louis
Yasin, Fazle M St. Louis
Yates, John M Jefferson City
Yoo, Chong-Sup Festus
Zia, Rashid Bridgeton

PD-PEDIATRICS

Accardo, Pasquale J St. Louis
Aceto, Thomas , Jr. St. Louis
Adams, W. Stuart Florissant
Allen, Jerry H Washington
Allphin, Barbara J Kansas City
Altemeier, William A, III Columbia
Alul, Mohammad Ali H St Charles
Amjad, Mohammad T St. Louis
Andrews, Elizabeth J Springfield
Barker, Edward T St Louis
Barter, Bruce Kansas City
Barton, Jean C Kansas City
Beidle, Raymond J Bridgeton
Belen, Marietta Festus
Benoist, Walter F Chesterfield
Birmingham, Jean E St. Louis
Blanton, Jos C Sikeston
Blim, R. Don Kansas City
Bloomberg, Gordon R St. Louis
Bock, Linda P St. Louis
Bordy, Marvin D Kansas City
Bouhasin, John D St Louis
Bowers, James E St. Louis
Britton, Loretta M Kansas City
Bunge, Nancy J Mexico
Burgdorf, Max H Bridgeton
Burris, Garrett C St. Louis
Burry, Virgil F Blue Springs
Bussmann, Yvonne L Springfield
Cabal, Maria E. St. Louis
Carnahan, Chas E Columbia
Casey, Eliot C St Louis
Ceaser, Nancy H Springfield
Chand, Nazar Poplar Bluff
Charette, Richard P Kansas City
Chun, Chung S Kansas City
Clark, Granville E Kansas City
Clever, Henry W St Charles
Clothier, Robt W Independence
Cockerell, Charles F Blue Springs
Cokingtin, Leovigildo C Independence
Collins, Douglass D Springfield
Cook, Katherine S Rolla
Cygan, Ronald W Kansas City
Daily, Donna K Kansas City
Dempsey, Maureen E Columbia
DeSilva, Ananda Hazelwood
Diehl, Elizabeth W St. Louis
Diemer, Jean Cape Girardeau
Dinkins, James A Cape Girardeau
***Downing, Gregory J** Shawnee Mission
Duling, Gerald J St Charles
Edmonds, Robt W Chesterfield
Edwards, Charles F Moberly
Epstein, Jay S St.Louis
Farberman, Elliott Florissant
Fernandez, Fernando St Joseph
Fitzmaurice, Laura S Kansas City
Floyd, Marla J Springfield
Flug, Eric J St. Louis
Forgue, Donald R Kansas City
Friedman, Robt H St. Louis
Gauer, Robt J Kansas City
Gellman, Elliot F St Louis
Glines, Michael H Arnold
Glotzbach, Ellen S Kansas City
Goerz, Ann A Blue Springs
Golden, Samuel E Springfield
Goldkamp, John D St Charles
Goldstein, David E Columbia
Griesemer, Bernard A Springfield
Groshong, Ted D Columbia
Grunt, Jerome A Kansas City
Guyer, Emily Columbia
Hall, Robt T Kansas City
Hamburg, Frederic L Springfield
Hanks, Michael S Springfield
Hansen, Thomas L Independence
Harris, David J Kansas City
Harris, Weldon L Independence
Harrison, Thomas J, Jr. St. Charles
Harwell, J. Larry Clayton
Hellerstein, Stanley Kansas City
Hellweg, Raymond W Florissant
Henry, Roy A Springfield
***Hey, Dennis J** Kansas City
Ho, Judith E St. Louis
***Hoffman, James E** Cape Girardeau
Holland, Robt D Springfield
Holleman, David N Kansas City
Holmes, Nancy E St. Louis
Horan, John J, Jr. St. Louis
Howard, Campbell P Kansas City
Hsu, Cecilia C Overland Park
Ip, Aidan W St. Louis

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*Doctor of osteopathy.

Jackson, Mary Anne Kansas City
James, Elizabeth J Columbia
Jones, Patricia E Kansas City
Jones, Robert R Nevada
Kahn, Joseph A St. Charles
Kanarek, Joseph Kansas City
Keating, James P St Louis
Keefe, David M St Charles
Kemp, Michele E Chesterfield
Kesssinger, William A Springfield
Khan, Abdul G Arnold
Khurana, Satish K Lenexa
Kilbride, Howard W Kansas City
Knapp, Jane F Kansas City
Knock, Henry L St. Louis
Kreusser, Katherine L St. Louis
Krishna, Padma Kansas City
Kronemer, Norton S St. Louis
L'Ecuyer, Jerome L St Louis
Lass, Nancy A Brentwood
Latimer, Walter N Gladstone
Levie, Benton B Sikeston
Lieb, Francis X Richmond
Limpiphiphatn, Ester P Perryville
Livingston, Don G Ballwin
Lyss, Stanley B St Louis
Mann, James K Hannibal
Mantovani, John F St. Louis
Matthews, Thomas D Washington
McCrory, James H Springfield
McIntosh, Michele C Independence
McKinney, Daniel C Springfield
McNeal, Douglas M Springfield
Mestres, Hugh M St Louis
Metzl, Kurt Kansas City
Meyer, John W Springfield
Mitra, Nirmal K Kansas City
Monteleone, Patricia L St. Louis
Morris, Barbara A Kansas City
Motier, Thomas H St. Louis
Muraywid, Ahmad H Mexico
Murphy, Timothy P St. Joseph
Naime, Mansour J Kansas City
Nash, Homer E, Jr. St. Louis
Newman, William R Joplin
Nicholis, G. Ronald Kansas City
Nussbaum, Larry Liberty
O'Neil, Jerome H, Jr. St. Louis
Olson, Lloyd C Kansas City
Oppermann, Karen J Kansas City
Overend, Don S Springfield
Palcheff, Chris L Springfield
Pardo, Lourdes S St. Louis
Pehlman, Jos E Malden
Perryman, Kathy M Kansas City
Peterson, Frederick D St Louis
Phillips, Abraham M St. Louis
Pitiyanuvath,Tasanaporn Kansas City
Pittman, Susan St Louis
Plax, Steven I St Louis
Powell, Alan E Independence
Powell, Cynthia K Farmington
Prokop, Joseph R St. Joseph
***Ramsey, Jesse R** Cape Girardeau
Reister, Dorothy D Kansas City
Rejent, Anthony J St Louis
Reyes, Lirio M Springfield
Rice, Kathleen G Springfield
Rising, Dean R Springfield
Roberts, Charles C Kansas City
Roberts, Phyllis G St Joseph
Ross, Wm J Bridgeton
Rowland, J. Christopher Lee's Summit
Ryser, Carol A Kansas City
Sakmar, Douglas A St. Louis
Sammon, T James Springfield
Sato, Geo Chesterfield
Sato, Richard W Chesterfield
Schlansky, Howard J St. Charles
Schmidt, Martin P St. Louis
Seshumurty, Ponnuru Mission
Seshumurty, Vimala Overland Park
Shapiro, A. James Springfield
Sharma, Vidya Kansas City
Sharp, Austin R Ballwin
Sheehan, Michael B Kansas City
Sherman, W. Gary Chesterfield
Simon, David L St. Louis
Simons, Paul S St. Louis
Smith, Elbert E Kansas City
Smith, Katherine W Kansas City
Snyder, Christopher H, Jr Springfield
Solanki, Nareshkumar J Wentzville
Soucie, Carol J Arnold
Spewak, Robert D St. Louis
Sponenberg, Don D Springfield
Stiaszny, Louis K Kansas City
Stith, John A St. Louis
Sultan, Tipu Florissant
Suseela, Dasari Kansas City
Suvan, R Poplar Bluff
Tarantino, Celeste Kansas City
Tenney, Jackie Kansas City
Tenorio, Gene Springfield
Thibeault, Donald W Kansas City
Thompson, F Gregg St Joseph
Tillman, Mary A St. Louis
Trimmer, Jeanne M St. Louis
Triska, Roland A St. Louis
Tschudin, Garland St. Louis
Tsifutis, Argyrios A Bridgeton
Tungsiripat, Soros Kennett
Umar, Ibrahim S St. Charles
Vaughters, Frank M Kansas City
Veenstra, Sallie L Lee's Summit
Vietti, Teresa J St. Louis
Walentik, Corinne St Louis
Walker, Orville C Independence
Warady, Bradley A Kansas City
***Wasserman, Gary S** Kansas City
Waters, Jeffrey A Kansas City
Waxelman, Roger J Ballwin
Weldon, Virginia V St. Louis
Westerfeld, Roy A St Charles
Wilcox, Ruth E Joplin
Williams, Kathleen M Kansas City
Williamson, Mark B, Jr. Kansas City
Wimmer, Warren J Florissant
Woods, Gerald M Kansas City
Wool, Gerald St Louis
Zahn, Robt L Springfield
Zuerlein, Terrance J Kansas City

PDA-PEDIATRIC ALLERGY

Cannon, Richard E St. Charles
Corry, James M St. Louis
Leslie, Stephen A Kansas City
Loren, Michael L Independence
Perez, Jeannie O Bridgeton
Portnoy, Jay M Kansas City
Schulman, Jeffrey I St. Louis
Siegel, Charles Gladstone
Wall, Lester E St. Louis

PDC-PEDIATRIC CARDIOLOGY

Canent, Ramon V Kansas City
Gowdamarajan, Rengasamy Kansas City
Hubbell, Marius M, Jr. Kansas City
Scagliotti, Daniel Kansas City
Wagman, Armin J Springfield

PDP-PEDIATRIC PULMONOLOGY

Rubin, Bruce K St.Louis

PDR-PEDIATRIC RADIOLOGY

Roberts, Fred F Kansas City

PDS-PEDIATRIC SURGERY

Amoury, Raymond A Kansas City
Ashcraft, Keith W Overland Park
Cradock, Thomas V St Louis
Danis, Richard K St Louis
Helikson, Mary A Columbia
Holder, Thos M Overland Park
Murphy, John P Overland Park
Sharp, Ronald J Overland Park
Ternberg, Jessie L St Louis
Weber, Thomas R St. Louis

PH-PUBLIC HEALTH

Biery, Richard M Kansas City
Claseman, Wilma W St Louis

PM-PHYSICAL MEDICINE & REHABILITATION

Al-Shathir, Saad Joplin
Alias, Susy St.Louis

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*Doctor of osteopathy.

Conway, Robert R Columbia
*Cooper, Glen E Columbia
Dang, Phung T St. Louis
Garfinkel, Lester S Kansas City
*Guenthner, Brenda L Jefferson City
Kelly, Charles R Kansas City
Lieb, Thomas F Clayton
Lytle, Edwin L St. Louis
Machek, Otakar St Louis
Mauldin, Charles C Springfield
Mohsen, Aly M Springfield
Pryor, Harold J Kansas City
Randolph, Bernard C, Jr. St. Louis
Ravi, Latha St. Louis
Romanace, Jean P Mt. Vernon
Wice, Martin B St. Louis
Zarr, James S Kansas City

PS-PLASTIC SURGERY

Abend, Melvin N Kansas City
Barnthouse, Joseph R Kansas City
Bennett, Danny L Kansas City
Brennan, Danl J St Louis
Cabbabe, Edmond B St. Louis
Callegari, Paul R St. Louis
Caplin, David A St. Louis
Chandler, Robt A Kansas City
Coin, Richard E St. Louis
Corwin, Kenneth D St. Louis
Crandall, Richard E Chesterfield
Croll, Gregory H Columbia
Crow, Martin L Kansas City
Danielsson, Ernst P Springfield
DePriest, Michael D St. Joseph
Domann, Darrel D Springfield
Eades, Joseph W Chesterfield
Ettelson, Charles D Chesterfield
Feliciano, Wilfrido C Maryland Hghts
Fortin, Don G Kansas City
Francel, Thomas J St.Louis
Gaska, Walter J Springfield
Geraghty, Thomas E Kansas City
Geter, Rodney K Springfield
Goldstein, Marcy A Pacific Palsade
Gutek, E. Philip Kansas City
Halford, Richard M St. Louis
Hart, William G, Jr. St. Louis
Harvey, Harold D Springfield
Heimburger, Richard A Columbia
Higgs, Philip E St. Louis
Holtmann, Barbel St. Louis
Hopkins, James P Kansas City
Howard, Richard J Blue Springs
Huffaker, William H Chesterfield
Iacobucci, John J St. Louis
Iyer, Manny S Kansas City
Johnson, Charles J St. Louis
Kaplan, Michael F Columbia
Khouri, Roger K St. Louis
Kofkoff, Richard L Bridgeton
Kraemer, Bruce A St. Louis
Lakusiewicz, Ronald J Poplar Bluff
Lamb, Jerome P Blue Springs
Lockwood, Ted E Overland Park
Lund, Herluf G, Jr. Glendale
MacKinnon, Susan E St. Louis
Marsh, Jeffrey L St Louis
McGuire, Patricia A St. Louis
Meystrik, Rosellen S Springfield
Mischnick, Carol R Chesterfield
Mosbacher, Hugh E Lee's Summit
Mossie, Raymond D Gladstone
O'Connell, Timothy St. Louis
Onken, Henry D St Louis
Paletta, Christian E St. Louis
Pappalardo, Carlos St Louis
Payne, Meredith C Chesterfield
Puckett, Charles L Columbia
Reddy, R. Ramachandra Cape Girardeau
Ribaudo, J. Michael St. Louis
Rottler, Paul D Fenton
Ruehl, Albert F St Louis
Scheu, James H St. Peters
Shehadi, Sameer I St. Louis
Sherrod, Duane W Joplin
Shively, Raymond E St. Louis
Stromberg, Brent V St. Louis
Swanson, Eric Kansas City
Thompson, Frederick E Liberty
Tobin, Gregory A Cape Girardeau
Waldorf, James C Kansas City
Wall, Norman R Springfield
Walton, Patrick J Kansas City
Webb, Harry E Kansas City
Webber, William B St Louis
Weeks, Paul M St Louis
White, Bruce I St. Louis
Winsky, Arlen D Springfield
Young, Vernon L St. Louis

PTH-PATHOLOGY

Allen, James H St. Louis
Anderson, Douglas A Springfield
Arnold, Lowry K Blue Springs
Arthaud, J B Columbia
Bari, Wagih A St. Louis
Beatty, Eugene C Shawnee Mission
Benson, Russell L Kansas City
Blair, Olga M St Louis
Bollozos, George D Ballwin
Bourgeois, Curtis H Columbia
Boyce, John M Sedalia
Brangle, Robt W St Louis
Breckenridge, Robert L Kansas City
Bucher, William C Columbia
Burch, Timothy K Overland Park
Caffrey, Raymond J Independence
Callaway, Lawrence A Kansas City
Carlson, John V Mexico
Carnes, Victor M Joplin
Case, Mary E St. Louis
Caughron, Michael R Kansas City
Cento, Donald Sikeston
Costin, Jimmy L Poplar Bluff
Craver, Jeffrey L Bridgeton
Cummings, Kenneth C Kansas City
Curry, Michael D Columbia
Dehner, Louis P St. Louis
DeFeo, Theodore C Kansas City
Dorzab, William E Kansas City
Duensing, George F Springfield
Dumadag, Virgilio P St Louis
Durr, Jon W Florissant
Esther, John R Joplin
Evans, George A Columbia
Ferris, Charles W, Jr. St. Louis
Fink, Roger L Springfield
Flynn, James M Kansas City
Fritzlen, Thos J Overland Park
Galblum, Larry I Kansas City
Gauthier, Charles P Kansas City
Gerdes, John A Springfield
Givler, Robt L Kansas City
Gresick, Robt J St Louis
Hall, Stanley G Hannibal
Hamel, Peter C Hannibal
Harding, Clarke T St. Charles
Henry, Lawrence D Columbia
Henry, Mary M Kansas City
Horn, Paul C Cape Girardeau
Hosler, Mark W Cape Girardeau
Hurly, Michael P Joplin
Johnson, Gareth R Independence
Johnson, Gordon L Festus
Johnson, Jonathan H Poplar Bluff
Johnson, Steven M St. Louis
Jones, Randall W Independence
Kang, Juan St Louis
Keitges, Pierre W Overland Park
Kerley, Spencer W Overland Park
King, Gregory S St. Louis
Kissane, John M St. Louis
Kleopfer, Lynn L Moberly
Kraus, Frederick T St Louis
Landy, Richard St. Louis
Laux, France A St. Louis
LaBach, James P Overland Park
Lewis, Noel R Springfield
Liao, Kun T St. Louis
Litton, Nancy J Independence
Lombardo, Joseph A St. Louis
Marshall, Hal E Kansas City
Martin, Scott A Chesterfield
McDonald, Margaret E Joplin
McIntire, Timothy L Jefferson City
McMeekin, Sheila P Overland Park
Millet, Ruth E Kansas City
Morrison, R. Gideon Sedalia
Mosby, Larry D Columbia
Moya, Carlos E St. Joseph
Mueller, John J St. Louis
Nomura, Roy M St Louis
O'Kell, Richard T Kansas City

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*Doctor of osteopathy.

Ost, Mark D Kansas City
Parker, Joseph C, Jr Louisville
Partap, Prabha St Louis
Patrick, Roman L St. Louis
Perez, Blanca M St. Louis
Perna, Vincent P St. Louis
Pittman, David L Columbia
Pittman, Gerald R St. Louis
Prey, Marianne U St. Louis
Qazi, Nasreen St. Louis
Racela, Antonio S, Jr. Shawnee Mission
Rao, Sumati St. Louis
Rawson, Perry G Washington
Rippey, John H Kansas City
Rollo, John L St. Louis
Salvador, Antonio St. Louis
Santillano, Antonio B St Louis
Seitz, Elson F Independence
Shah, Sheila St. Joseph
Short, Charles D St. Louis
Siegel, Carl D Kansas City
Silliman, York E St Joseph
Slahorek, George J Ft Leonard Wood
Smid, David M Springfield
Somoza, Jose R Kansas City
Spollen, Linda E Columbia
Stahr, William D Cape Girardeau
Steigman, Carmen K St.Louis
Sueper, Robert H St. Louis
Talbott, Lawrence B Kansas City
Tombridge, Thomas L Springfield
Tsai, Cheng C St. Louis
Turgeon, Ronald P St. Louis
Vergara, Gerardo G Kansas City
Villanueva, Angela A Overland Park
Vo, Thuy-Lieu T St. Louis
Wachter, Ronald M Springfield
Waxman, Dan A Kansas City
Weis, Landy St. Louis
Wick, Mark R Fenton
Zacharias, Sara Columbia
Zink, Thomas K St. Louis

PUD-PULMONARY DISEASE

Beller, Thomas A Kansas City
Bower, James S Kansas City
Brabson, John H Springfield
Bradley, James K Kansas City
Brook, Charles J Kansas City
Coulter, James W Springfield
Devins, George S Kansas City
Dew, Thomas A Chesterfield
Forsythe, Lees C Kansas City
Goheen, John R Kansas City
Hargis, James L Springfield
Harrison, Garth F Kansas City
Heinz, George Springfield
Hof, David G Kansas City
Hollinger, Lloyd A Shawnee Mission
Kapitan, Kent S Kansas City
Khan, Khalid I Cape Girardeau
King, John V, Jr. Ballwin
Lampton, Lawrence M Columbia
Lem, Vincent M Kansas City
Lerner, Scott A Kansas City
Mahmoud, Said F Kansas City
Pingleton, William W Shawnee Mission
Reddy, Anchala N West Plains
Scacewater, Rick Joplin
Schacht, Lawrence R Lake St. Louis
Schlozman, Danl L Kansas City
Siler, Thomas M St. Charles
Spence, Thomas H, Jr. St. Louis
***Thomas, Norvin E** Mexico
Trombold, Walter S Kansas City
Waxman, Michael J Kansas City
Wiant, James R St Louis

R-RADIOLOGY

Abodeely, Daniel A St. Louis
Acuff, R. Phillip St. Joseph
Al-Aly, Robert M St. Louis
Anderson, Dixie J St. Louis
Archer, Carol R St. Louis
Augustin, Cesar St. Louis
Bankuti, Ferenc Kansas City
Bardsley, John L St Louis
Bartholomew, Kenneth K Quincy
Barton, Premsri T St. Louis
Baskurt, Mehmet V Poplar Bluff
Baula, Armindo G St. Louis
Berni, Anthony A St Louis
Boles, Murray Columbia
Brodeur, Armand E St. Louis
Busse, Paul P St. Louis
Cabal, Edito St. Louis
Campbell, William S, Jr Cape Girardeau
Carls, Garry L Cahokia
Cohen, Edward St. Louis
Colbert, Robt S Sikeston
Cook, Marvin St Louis
Courter, Larry P Osage Beach
Cowan, John H Overland Park
Crepps, Louis F St. Louis
Cusumano, Joseph V St. Louis
Davidson, Kendrick C Leawood
Dehner, Jonathan D St. Louis
Destouet, Judy St. Louis
Devineni, V. Rao St. Louis
DeMotte, Jeanne M Richmond
Diemer, David P St. Louis
Diemer, Peter A St. Louis
Drisko, Jeanne A Kansas City
***Dykstra, John S** Kansas City
Egan, Thos F St Louis
Ely, Norman B Springfield
Ernst, Richard E Bridgeton
Evens, Ronald G St Louis
Every, Pamela D Cape Girardeau
Farkas, James R Sedalia
Fisher, Jos L St Joseph
Francisco, Dominic S St. Louis
Garvin, Charles F Chesterfield
Geisse, Guillermo St Louis
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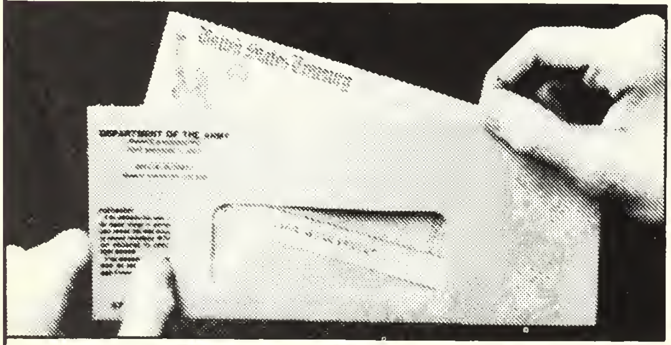

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222 — WASHINGTON UNIVERSITY

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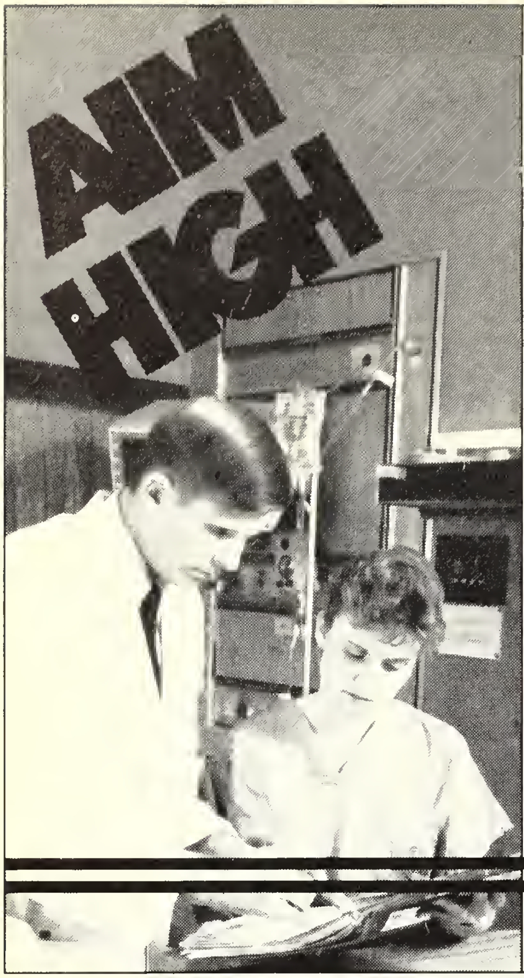

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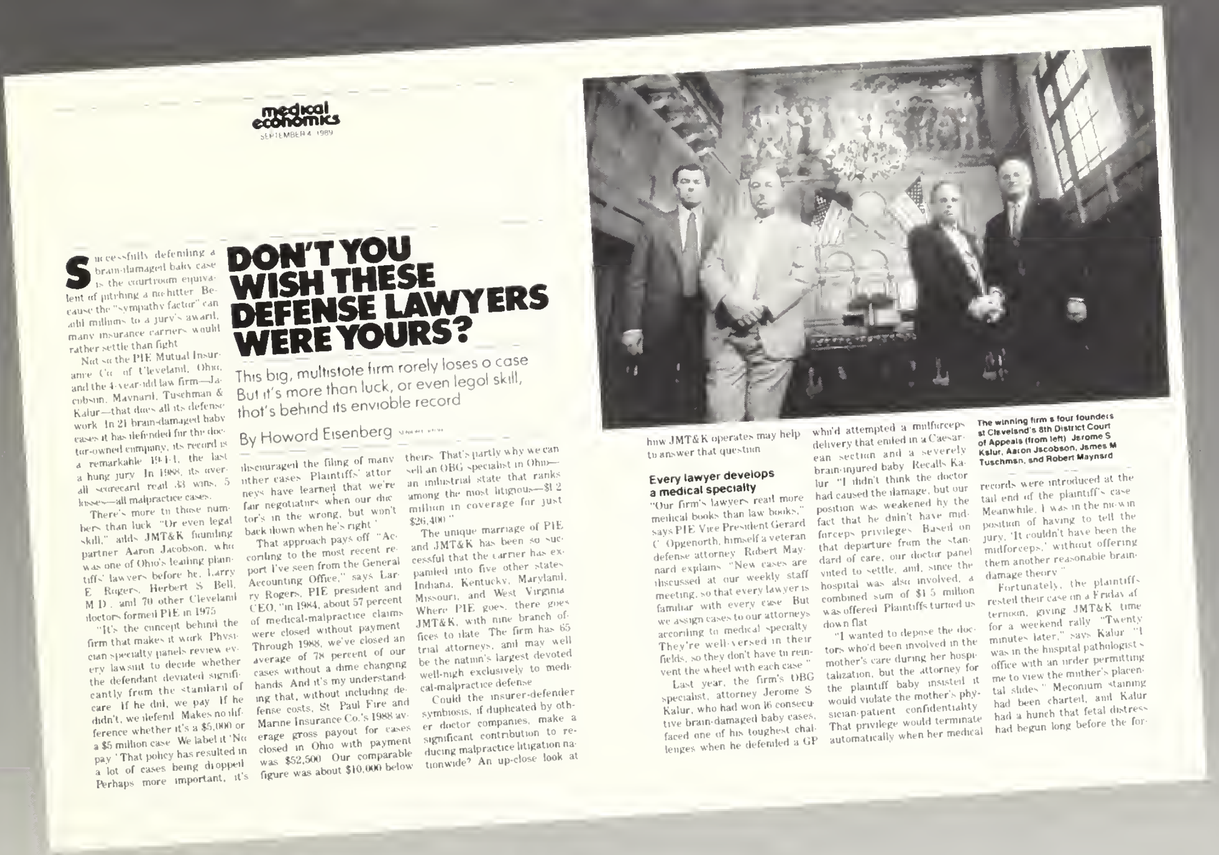

medical economics
SEPTEMBER 4, 1989

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record

By Howard Eisenberg

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the PIE Mutual Insurance Co. of Cleveland, Ohio, and the 14-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988, its overall scorecard read 33 wins, 5 losses—all malpractice cases.

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed PIE in 1975.

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a $5,000 or a $5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, PIE president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was $52,500. Our comparable figure was about $10,000 below theirs. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—$1.2 million in coverage for just $26,400."

The unique marriage of PIE and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where PIE goes, there goes JMT&K, with nine branch offices to date. The firm has 65 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says PIE Vice President Gerard C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP who'd attempted a midforceps delivery that ended in a Caesarean section and a severely brain-injured baby. Recalls Kalur: "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of $1.5 million was offered. Plaintiffs turned us down flat.

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical records were introduced at the tail end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain-damage theory."

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-

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Owned and edited since 1904 by the Missouri State Medical Association. *Missouri Medicine*, Journal of the Missouri State Medical Association, is published monthly at 113 Madison, Jefferson City, Missouri 65102. Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices. Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept. P.O. Box 1028, Jefferson City, MO 65102.

The subscription price per year for nonmembers is $20.00. Annual subscription for members is included in the annual membership dues. The international subscription price is $40.00. Single copies are $4.00 and the cost of copies of the annual August Directory issue is $15.00.

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Printed by the Ovid Bell Press, Inc., Fulton, Missouri 65251.

CONTENTS

VOLUME 89, NUMBER 9

Perspectives

Food For Thought
Craig S. Holzem, M.D. 675
Humor Is Good Medicine
George M. Bohigian, M.D. 679

Poetry

Romancing The Stone
S.D. Madduri, M.D. 686

Editor's Desk

You Have Our Address
J. Regan Thomas, M.D. 651

Scientific Articles

A Prospective Study of the Transition to Phacoemulsification and Small Incision Cataract Surgery
John C. Hagan,III, M.D. 663

Esophageal Stricture: Results of Dilation of 300 Patients
Leslie E. Tucker, M.D. 668

Skin Expansion as Preparation for an Opening Wedge Osteotomy of the Mid-foot in Arthrogryposis
Norman D. Buebendorf, M.D., Matthew J. Concannon, M.D., Robert W. Gaines, M.D., and Charles L. Puckett, M.D. 671

Departments

MSMA Officers, Councilors and Delegates 649
Letters to the Editor 653
President's Page 657
Practice Management 659
Auxiliary Message 661
Physician Recognition Awards 681
Disciplinary Actions 682
Residents' News 685
New Members 687
In Memoriam 693
Medical School and Member News 694
CME Calendar 697
Classified Advertisements 699
Information for Contributors 701

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MISSOURI MEDICINE

Journal of the Missouri State Medical Association

Vol. 89, No. 9 September 1992

September Cover
"Ducks Have Gone Home", a 24"x30" oil on canvas, is by Shirley Chao Ting. The artist was born by the Li River in China in 1939. Her name means "Beautiful Li River". Now a Supervisor with the Veterans Administration Medical Center Library Service in Kansas City, she became interested in painting while touring Europe and decided to begin painting on her 50th birthday. The building depicted is an old mill near Parkville, Missouri.

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J. Regan Thomas, M.D., Editor

The Editorial staff and I have been quite pleased with the many supportive notes and comments about the changes and directions of the Journal. I will continue to pursue my goal of developing a more interactive publication, providing a forum for Missouri physicians. Controversial topics will not be avoided as long as opposing views also have equal opportunity for publication. You have already seen an expanded "Letters to the Editor" space and we are delighted with the increased interest from our readers. Likewise, both scientific papers and socioeconomic issue contributions are on the rise. A trend which I hope will continue.

Medical journals typically can only publish what is received in submission. Overall, *Missouri Medicine* relies heavily on papers submitted spontaneously by members of the Missouri State Medical Association and other physicians of our state and region. True enough, but as our editorial staff will attest, this Editor also feels the responsibility to also solicit, beg, harass, or cajole possible authors to submit contributions.

We should not however, and do not, accept all papers and materials that we receive. I thought it might be helpful at this time to review the process that leads to publication in *Missouri Medicine*. In other words, what do we look for when a paper is reviewed? How is the process of peer review by members of the MSMA utilized in evaluating papers submitted for publication?

First, there are certain "logistic" limitations to what can be published. We have received several requests to reprint various materials which practically exceed our total space available for the entire journal. There are of course basic limitations related to space, financial and budget considerations, and archival resources which impose limits on what we can publish. There are also basic levels of quality, form, and tone which must be maintained to keep the journal at a level acceptable to the MSMA and the journal's readership. That is why we have an Editor. It is why, in my opinion, the course, style and direction of *Missouri Medicine* should be guided by a "hands on" physician volunteer (the Editor) and not solely staff driven.

It follows that the net effect of these forces requires some selection process to be utilized to accept or reject articles for publication. Scientific articles all go through a process of peer review. Based on the topic or area of interest they are assigned for review by one or more members of the Editorial Board. Occasionally, additional reviews are also requested of MSMA member physicians in the specialty area involved. The papers must conform to the format outlined in "Information for contributors" published in the journal (see page 701). The reviewers are also expected to provide the Editor with an opinion on the article's scientific reliability, clinical or scientific importance, and originality of the paper. One other area is also considered: Since this is a state journal a certain degree of relevance to Missouri physicians is desired. When there is disagreement between reviews, the tie is broken by the Editor. Occasionally an additional reviewer is also requested if the Editor feels it would be helpful. These steps are common practice at all medical and scientific journals and continue to serve *Missouri Medicine* well. These steps do not eliminate the disappointment of the authors whose submissions are rejected, but it is none the less fair. It does not eliminate controversy or differing opinions by those who read the published reports. It does however provide those individuals with an equal opportunity to publish their own clinical experiences and scientific findings with the same scrutiny and fair evaluation process.

Non-scientific contributions, poetry, and essays are all evaluated by the Editor with input from the staff. The policy is quite open if within appropriate boundaries of good taste, fairness, and quality. Opposing views are given equal access.

Cover art is selected by the staff with rough guidelines by the Editor. We try to use Missouri oriented submissions with Missouri physician submissions given priority. I have asked that the cover margin colors be selected to coordinate with key colors from the art work. The staff has done an outstanding job with this and we are frequently complimented on the appearance of the journal.

There are occasional stumbling points in all of this activity. We will always make an effort to benefit from the learning process provided by those occasional missteps. There is plenty of room for everyone in this journal. Your participation will make us better and benefit your colleagues. You have our address....Join us soon! ❐

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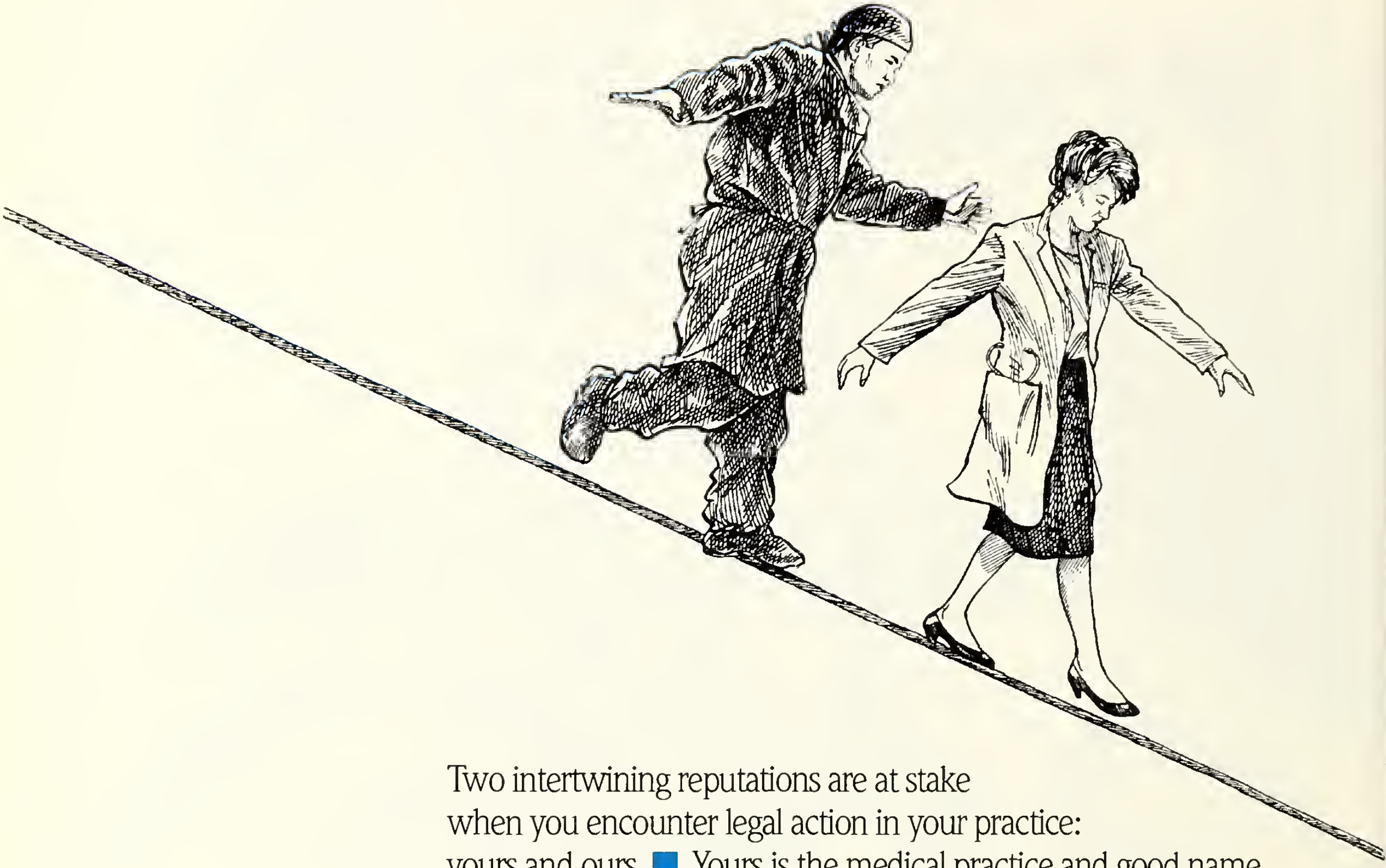

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Dear Editor:

To begin, I want to applaud the tick research efforts (Hall, et al, "Research on Ticks and Tickborne Pathogens in Missouri - An Interim Research Report" June 1992 *Missouri Medicine).* However, I have problems with some of the conclusions. First, percentages were given but no hard numbers or methods were presented. Are these percentages of what? Without knowing the sampling size, it is hard to make a judgement on the relevance. The authors both start and end the article by writing about Lyme disease and emphasize that they found no evidence by their methods of *B. burgdorferi* in Missouri and conclude that it is "highly unlikely" that they would have missed such evidence. I have serious problems with that conclusion and the reasons are listed below.

1) This study is at variance with previous studies and experiences of other researchers in Missouri, including some very large and statistically relevant tick samples (e.g. Feir and Reppell, who found 2.3% of *Amblyomma americanum* (Lone Star ticks) were infected).

2) The CDC found ticks in southeast Missouri that stained with monoclonal antibodies for *B. burgdorferi* (H5332). They also visualized live motile spirochetes in these ticks that were morphologically consistent with *B. burgdorferi.*

3) The conclusions are at variance with other studies (some published and some soon to be published) in the south and in areas not known to have *I. dammini.*

4) The author has two stains, a polyclonal which is presumed to be used as a screen and a monoclonal which he says he will use for specificity. He then diluted the polyclonal antibody to the minimum concentration that would stain his laboratory controls. I question the wisdom of doing this in an area where the probability of antigenic variance is high (different tick vector) and thus the antigen "match" is likely to be less than perfect. If the polyclonal is to be used as a screen then why would one deliberately reduce the sensitivity? I would have done just the opposite. I would have enhanced the sensitivity of the polyclonal stain and then used the monoclonal for specificity. This study used the polyclonal to "minimize cross reactivity" and deliberately reduced the sensitivity such that there were no spirochetes picked up to even try the monoclonal on for specificity. I know from personal experience that other researchers in Missouri have done just the opposite. They have concentrated, not diluted, the polyclonal and then have used the monoclonal for specificity. To me that makes more sense and reduces the risk of missing the spirochetes altogether.

5) To draw the author's conclusions one has to determine that *B. burgdorferi* are relatively evenly distributed throughout the state. The data do not support that. Even in a tiny geographic state such as Connecticut, Lyme disease is focal. In fact, in the June issue of *The Journal of Clinical Microbiology* in which Marnarelli et al found a widespread incidence of very convincing serological evidence of *B. burgdorferi* in rodents throughout the south, they obtained some of the negative controls from northwestern Connecticut, where Lyme disease is rare. Obviously, it occurs with great frequency in other areas of the state.

6) If one is to conclude that *B. burgdorferi* does not exist in Missouri from this study then I find it puzzling that no samples were taken from the top four counties where clinical cases of Lyme disease have been reported and, when investigated, met CDC criteria. In fact, these four counties accounted for 57% of all clinical Lyme cases through 1991 and yet no ticks were collected from those counties.

Next, there were only two small and focal collection sites in southeast Missouri. One barely in southeast Missouri in Carter County where only nine cases through 1991 have been reported and the other in the backyard of a non-Lyme patient in Stoddard County. Neither collection site was associated with clinical Lyme disease.

7) Other researchers have implicated the Lone Star tick as the primary vector of clinical Lyme disease in Missouri. The numbers of Lone Star ticks in areas with clinical Lyme disease reported were not given. Whether they are statistically significant given a previously reported infection rate of around 2 to 3 percent is unknown. Given the conclusions drawn, I do not understand why these numbers were not given. Specifically, how many Lone Star ticks in Stoddard County were examined?

In summary, I have a problem with the negative conclusions regarding *B. burgdorferi* when one considers the problem of antigenic variation and then dilutes a polyclonal screen to the minimum concentration that will pick up the highly antigenic laboratory controls, especially when one has a separate monoclonal to be used for specificity.

This study was done in such a way that there is no clinical or geographical correlation whatsoever with Lyme disease in Missouri and yet the conclusions are extrapolated to cover those very issues. The only tick collection site remotely close to the high incidence areas reported so far in Missouri was the backyard of a person without clinical Lyme disease. The conclusions from the study are at variance with other studies.

Again, I applaud the authors' research efforts as we all know that much more knowledge is needed. However, I do have some serious problems with their conclusions. I (do not) believe the study was designed primarily to show the absence of *B. burgdorferi* in Missouri, and it didn't. Additionally, the much publicized CDC "Missouri spirochete isolate" upon which some of the "Lyme-like" theories are based is not a true spirochete. Non-Lyme theories founded on this information are specious.

Ed Masters, MD
Cape Girardeau, MO
June 9, 1992

Dear Editor:

I have read the Feature Article in the June 1992 issue by Hall et al and I think your readers deserve some additional information. The number of ticks tested as well as the percentage positive for each pathogen is very important to allow the reader to make a judgement on the significance of the data. Collections were made in several parts of the state: were the percentages for the pathogens reported approximately the same for each habitat and all parts of the state? The only indication of any localization of a pathogen was for *F. tularensis*. It is a little hard to believe that the other pathogens were evenly distributed throughout the state; however, if that is true, it should be stated.

My primary concern with this paper is the conclusion that there are no *Borrelia burgdorferi* in Missouri because these authors did not find any. The senior author knows very well that my graduate student, Dr. Catherine Reppell, and I identified *B. burgdorferi* in both the Lone Star tick and the American dog tick (Feir and Reppell, 1990, MO Academy of Science Occasional Paper #8) by using the highly specific monoclonal antibody H5332. We have also had DNA-PCR and sequencing done on the spirochetes from ticks we have collected and the DNA was 97-98% homologous with B31. Spirochetes from a Missouri patient have been cultured by J. Rawlings in the Texas Department of Health. There are certainly some differences between the spirochetes we have found in Lone Star ticks and the spirochetes from *Ixodes dammini*; the principal difference is the inability to culture readily spirochetes from the Lone Star tick and American dog tick. However, it seems to be quite premature to conclude that "the Missouri situation involves a pathogen other than *B. burgdorferi* . . ." when there is currently no alternative explanation for the staining of the Missouri spirochetes with the specific MAb H5332 and their high level of DNA homology with B31.

I do not think any of the authors of this paper are epidemiologists or physicians and therefore neither they nor the study they are reporting are qualified to state that "There appear to be significant dissimilarities between the epidemiology of Lyme disease. . . from the northeastern U.S. and the syndrome currently affecting Missourians, although the latter seems to be a 'Lyme-like' . . .". Lyme disease is a clinical diagnosis by all current literature and symposia. The symptoms used by physicians in Missouri are certainly within the range of symptoms seen in other parts of the country. Until some concrete facts are presented showing that the symptoms here are definitely not Lyme, it is misleading if not irresponsible to confuse an already extremely difficult problem with terms like "Lyme-like", especially in a paper such as this one which had no stated objectives related to re-defining Lyme disease in Missouri.

Lastly, I must point out that the authors took a great many samples from each adult tick and it is possible that they did miss spirochetes. Ticks are rather well known to be distributed in a focal fashion and infected ticks are also distributed in a focal fashion except for areas with very high infestation rates. Therefore, depending on the number of ticks that were examined (and we do not know that from the paper), it is quite possible that the authors missed positive ticks. Even when we have sampled from an area from which we have obtained positive ticks on several prior occasions, we do not always obtain positive ticks. My principle concern is not so much with the authors' procedures as it is with their conclusions which are not justified by their data or by data available in the literature.

I would appreciate your printing this letter. I would also appreciate reviewing the letter before publication (if you decide to publish it) if you make any deletions or modifications to it.
Thank you.

Professor Dorothy Feir, Ph.D.
St. Louis University
June 12, 1992

Dear Editor:

The PIP visit I made April 22, 1992 was well worth the time. The introduction to the legislature, provided by Tom Holloway and Cork Swarens, was informative, and the openness of the capitol quite surprising. Certainly we will not win on all issues, but the day was an encouragement to keep trying. I look forward to a return engagement during the next legislative session, and hope to bring some of my colleagues as well.

Assistant Professor James W. DeBoard, MD

St. Louis University Medical Center
April 27, 1992

Dear Editor:

After serving nearly five years in the army and a residency in medicine I entered the practice of medicine in 1949 (in Monett, MO in 1956). During this period I got up every morning at 4:45 seven days a week to read and study in order to keep abreast of the new developments in medicine. After retiring in March 1982, believing it unnecessary, I discontinued this.

Each of the above years, through 1991, I completed the questionnaire, paid the fee, and renewed my state license. I received a letter dated May 27, 1992 from the office of the State Board of Registration for the Healing Arts that if I wished to renew my license for 1992 it would be necessary for me to complete the renewal application, pay the fee, and document the completion of 25 hours of Category 1 or 1A CME during the period February 1, 1992 through the present. Being retired I had not done the latter. Upon calling the office of the Board I was told that this academic requirement had been mandated by the members of the Board for all retired physicians in Missouri effective early in 1992.

This is a bad rap for all retired physicians in Missouri. In my opinion it is unnecessary, ridiculous, and shows a lack of compassion for the retirees of this state. We have become pawns of the bureaucracy.

This means that we must surrender our state and federal narcotic licenses and that we cannot lawfully prescribe, administer, dispense, or possess controlled substances in the state of Missouri.

This is unjust and reduces us, the retirees, essentially to non-medical entities. We deserve better treatment.

William J. Glass, Jr., MD
Nixa, MO
July 11, 1992

Correction:

The name of Calvin J. Curts, M.D., was listed incorrectly in the Courtesy Resolution on Deceased Members that was printed in the July 1992 issue of *Missouri Medicine*. We sincerely regret the error.

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Contracts

by Carol F. Williams, M.D.,

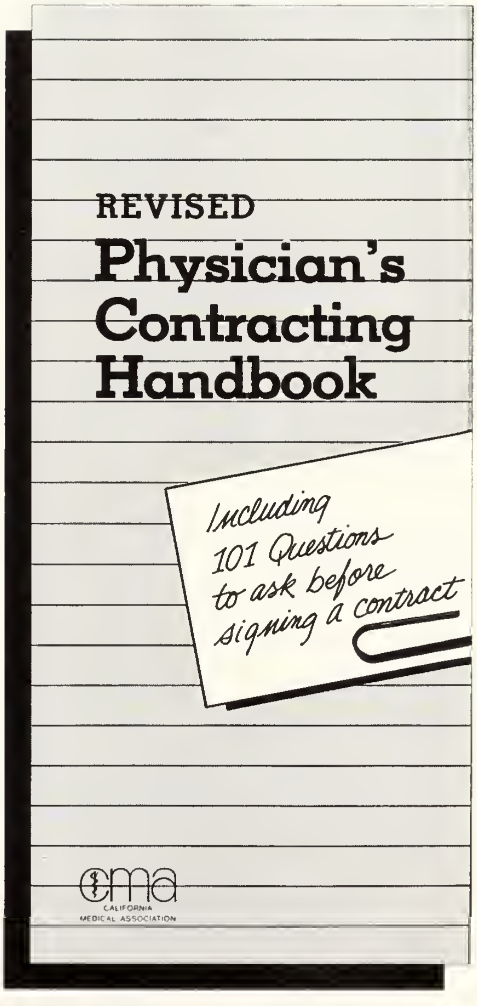
Missouri State Medical Association President

This summer, your Missouri State Medical Association has been involved in discussions with Blue Cross/Blue Shield of Missouri (BC/BS) over its proposed Alliance contract. The focus of these discussions has been on three major issues - the requirement that photocopies of complete patient records be made available to BC/BS upon request, the utilization of the Resource Based Relative Value Scale (RBRVS) system of reimbursement for physicians, and the requirement that all claims be electronically submitted through Health Care Interchange (HCI), an entity 35% of which is owned by BC/BS. The requirement that all claims be electronically submitted has been dropped; HCI will approach physicians separately from the Alliance contract to bid on their claims submission business.

The requirement of photocopies of complete medical records remains in the modified contract now distributed to physicians with the deadline for signing of August 18. Under this provision, a physician may not protect confidential information from disclosure to a clerk who is screening records for items which may indicate higher risk of liability for health care coverage. While psychiatrists' notes most commonly come to mind, it should be noted that obstetricians/gynecologists' notes frequently have information about sexual activity which should be regarded as privileged communication.

The RBRVS scale, originally developed by Harvard University with input from the American Medical Association at the urging of Congress, has been set into place in the Medicare system. Before RBRVS was implemented, however, it was severely modified by HCFA in a cost-cutting move and only the loud outcries of physicians from all over the country were successful in restoring some of the cuts. Even so, the AMA has given only a grudging "Let's give it a try" to RBRVS as it now stands. More specifically the recent AMA House of Delegates passed a resolution urging the insurance industry not to implement RBRVS in private health care plans until after Medicare RBRVS has had the kinks worked out of it. There is a considerable sense in the medical community that the BC/BS Alliance contract's utilization of RBRVS is a betrayal of the trust that should exist between the medical community and third party payors.

In sum, MSMA cannot tell physicians what to do about this or that contract but we will convey our concerns to the membership. Physicians would do well to have contracts reviewed by their accountants and/or their lawyers. *Physicians' Contracting Handbook,* published in 1985 under the MSMA seal, analyzes points to look for in contracts and can be made available again if desired by the membership. It is best to check the ingredients before biting off a mouthful of the sandwich. ❒



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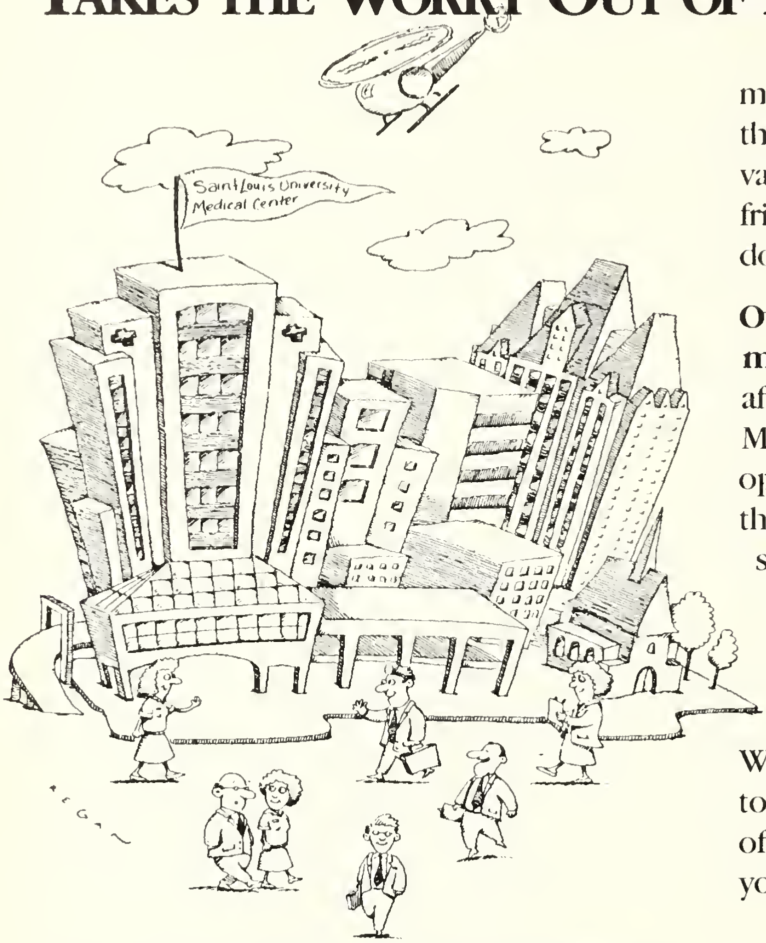
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Dear Dr. Woerth,

Is it true that you are no longer allowed to charge for post-operative complications? We have had Medicare deny payment on our claims. Also, how do you bill for medical services provided during post-operative times?

C.R.

Dear C.R.

In answer to your first question about billing for post-operative complications, you cannot bill Medicare patients separately for post-operative complications unless the complication requires a trip back to the operating room. Medicare considers its reimbursement for surgery to include the care and treatment of post-operative complications. If the patient is returned to the operating room during the post-operative period for a related procedure, the modifier 78 must be used in order for you to be reimbursed for the service(s) by Medicare. Modifier 78 was specifically written to indicate that the procedure required a return to the operating room during the post-operative period and was related to the original surgery. Frequently I am asked if the surgical suite located in a medical office qualifies as an operating room. The answer is yes.

This rule of not reimbursing separately for post operative complications is unique to Medicare and a few other insurance policies. In cases where a non-Medicare patient has post-operative complication, the service(s) rendered for treatment of the complication is billable. I have found that many offices are confused about this and thus are not charging non-Medicare patients for treatment of post-operative complications. As a result, these offices are losing hundreds (and perhaps thousands) of dollars in revenue each year.

Regarding your second question about billing for services provided during the post-operative period, if the service provided is unrelated to the original surgery, i.e. not the normal post-operative care, nor a post-operative complication, it is billed with the modifier 79. Modifier 79 indicates that the procedure or service performed was done during the post-operative period but was unrelated to the original procedure. Medicare will not pay for services rendered in the post-operative period unless this modifier 79 is appropriately used. Many medical office staff members report that their claims for post-operative services have been denied by Medicare because this modifier was not used. This denial of claims can be costly to medical offices and results in delayed reimbursement. I encourage all of you to carefully read through the modifiers listed in the 1992 CPT book on pages 563-567 so you might avoid payment denials and delays.

Dear Dr. Woerth:

We seem to have a difficult time in our office getting patients to pay their bills in a timely manner. Any suggestions how we might improve collections?

Dr. O.P.

Dear Dr. O.P.:

I hear about this problem from many physicians. It may be your billing procedures that are truly the problem. The vast majority of patients will live up to your expectations if you just let them know what you expect in terms of payment. So, if you want patients to pay their bills within 30 days of receiving their invoice, print a "date due" on the statement. Some physicians feel that such a phrase might be a bit offensive to patients and if you fall into this group I suggest more gently phrasing like; "We kindly request that your payment be made by [date]". And, if you expect patients to pay their bill in its entirety you might find this phrase to be more suitable; "We kindly request that your payment in full be made by [date]".

Many of my clients tell me that the use of these phrases on their statements have improved the timeliness of their patients' payments and, consequently, have eliminated the need to rebill patients. ❐

Do you have a question for Dr. Woerth? Include your questions along with your name, address and phone number and send them to:

Janice K. Woerth, Ph.D.
Practice Management
c/o *Missouri Medicine*
P.O. Box 1028
Jefferson City, MO 65102
Or call her direct:
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Although your name will not be used in *Missouri Medicine*, please include your name and phone number so that Dr. Woerth may contact you if she needs additional information to answer your question.

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Because of You

Nona Nan Chapman, MSMAA Vice President - Membership

The following words popped into my head one morning at 5:30 a.m. while thinking about the medical auxiliary and volunteering with this organization: "Because you are you and do what you do, someone out there is depending on you."

"Because you are you . . ." MSMA Auxiliary boasts quite an impressive wealth of talent. On the state board alone, we have two members with M.D. degrees, another with a Ph.D. in pharmacy, a CPA, MBAs, Nurses, musicians, educators and others.

" . . . and do what you do . . ." Medical auxiliary's purpose is to (a) assist in the programs of the Missouri State Medical Association that improve the health and quality of life for all people, (b) uphold the programs of the American Medical Association Auxiliary / Alliance, (c) promote health education, (d) encourage participation of volunteers in activities that meet health needs, (e) support health-related charitable endeavors and (f) coordinate and advise concerning the activities of the auxiliaries of the state's societies.

So, how are we fulfilling our purpose? The AMA Auxiliary / Alliance is giving assistance this year to the American Medical Society's emphasis on family violence in America. A formal program is in place to help educate our communities through medical auxiliaries on this all too long, overlooked subject. Your Missouri Medical Association Auxiliary has worked in coalition with other state agencies to produce a pamphlet on the dangers of shaking infants. These pamphlets are being distributed by auxiliary members in a statewide effort. We are very fortunate to have the services of these auxilians when there is such a demand and need for our time. While many work in their spouse's office or as professionals in other fields including homemakers, the need for our input into the community continues.

In an effort to broaden our scope in auxiliary, the AMA Auxiliary voted, this year, to change its name to the American Medical Association Alliance. The MSMA Auxiliary will be taking this change into consideration as we review our bylaws this year.

". . . someone out there is depending on you." We are not always able to give time to the auxiliary. When members cannot give their time, his or her membership dues are put to work regardless, making possible many of the auxiliary's projects, from scholarships to safe houses.

In order to continue our work, we need to help the members of the Missouri State Medical Association. Is your spouse a dues paying member of the state's medical auxiliary? If not, please complete the information below and send it along with your check to your county's medical auxiliary treasurer or the address listed on the form.

Because you are you and do what you do, encourage your spouse to get involved too. ❒

Yes, Please include me in this year's MSMA and AMA activities:

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A PROSPECTIVE STUDY OF THE TRANSITION TO PHACOEMULSIFICATION AND SMALL INCISION CATARACT SURGERY

By John C. Hagan, III, M.D.

Phacoemulsification is an increasingly popular method of performing cataract surgery. The procedure remains controversial. Opponents of phacoemulsification maintain the procedure has an unacceptably high complication rate during transition to the technique. This prospective study found that the many advantages of phacoemulsification were safely introduced into a moderate sized community practice. The surgical complication rate was very low and visual acuity statistics excellent.

Cataract formation, the loss of clarity of a human crystalline lens, is one of the most common manifestations of the aging process. Cataract removal combined with insertion of an intraocular lens (IOL) is the most common surgical procedure done on American adults. More than 1.3 million cataract operations will be done in the United States in 1992. Almost all of these cataract extractions will be done by an extracapsular technique coupled with insertion of a posterior chamber IOL.

In extracapsular surgery the lens nucleus and cortex are completely removed. The posterior lens capsule is left in place to support and position the IOL and to reduce the risk of retinal detachment and cystoid macular edema. Two forms of extracapsular surgery are used: planned extracapsular cataract extraction (ECCE) and phacoemulsification (PHACO). Which extracapsular technique is the best surgical procedure is arguably the most controversial and debated issue in contemporary Ophthalmology. A prospective study was designed to summarize the results of a community eye surgeon during the first year in which PHACO was his procedure of choice for cataract removal.

METHODS

Beginning in 1/1/91 until 8/31/91 all cases of cataract extraction and insertion of an intraocular lens were prospectively summarized. The cases were consecutive, unselected and represent the author's entire private cataract practice. Triple procedures (cataract removal, intraocular lens insertion and a glaucoma procedure) were excluded. PHACO was done on all cases, unless due to a small pupil, lens hardness, corneal dystrophy or weak zonules, ECCE was felt to be a safer procedure. All operative complications were recorded. Pre-operative and post-operative visual acuity was summarized for all cases. Visual acuity was determined with a refraction both pre- and post-operatively. Minimum follow-up was two months post-operatively. Over 90% of the cases have been followed for six or more months.

DESCRIPTION OF PHACOEMULSIFICATION PROCEDURE

All cases were performed by the author at North Kansas City Hospital, a 350-bed facility with an active, well-equipped and staffed Ophthalmology Service. The pupil was maximally dilated with 1% tropicamide, 2.5% phenylephrine and 1% cyclopentolate. Flurbiprofen was also used. Thirty minutes prior to surgery a Honan^R eye compressor was applied. Anesthesia was by a peri-bulbar injection through a 23 gage Alcon Thornton^R needle. The anesthetic mixture was 5-7 cc's of .75% bupivacaine and 2% xylocaine in a 1:1 mixture with hyaluronidase. The patient was taken to the operating room where the remainder of the procedure was completed with the Ophthalmic operating microscope. After prepping and draping in a sterile manner an incise drape was placed on the eye. An aspirating speculum was inserted to separate the lids. A superior rectus bridle suture of 6-0 silk was placed. A small fornix based conjunctival flap was created at the 12 o'clock position and the sclera lightly cauterized. With a Alcon Crescent knife a 5 mm partial thickness scleral incision was made 1.5 to 3.0 mm posterior to the limbus. The Crescent knife was used to extend the incision intrasclerally towards the limbus and about 1 mm into clear cornea. With a 3.1 mm Keratome (Figure 1) the anterior chamber (AC) was entered through the incision and the AC filled with a viscoelastic substance (Viscoat^R). After creating a small capsular tear with a cystotome a capsulorhexis forceps (Figure 2) was used to make a continuous, curvilinear capsulorhexis (CCC). Hydrodisection (Figure 3) was done with balanced salt solution. An Alcon

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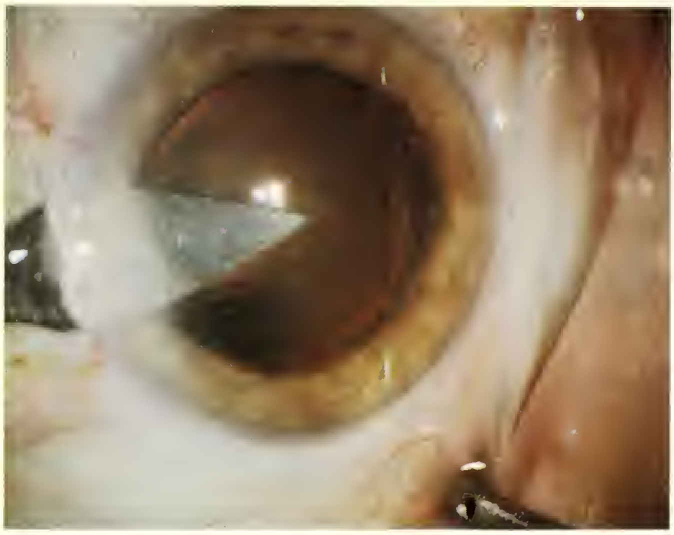

FIGURE 1. A 3.1 mm keratome is used to enter the anterior chamber (AC) through the superior, scleral tunnel incision.

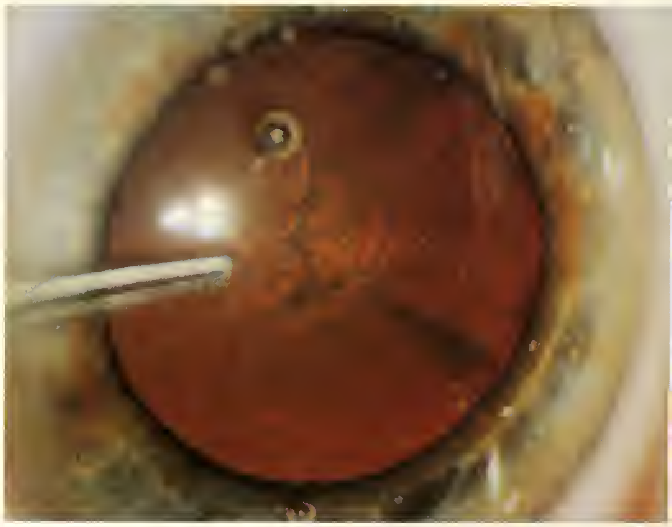

FIGURE 2. Using Viscoat to maintain the AC, a continuous, circular tear (capsulorhexis) is made in the anterior capsule with forceps.

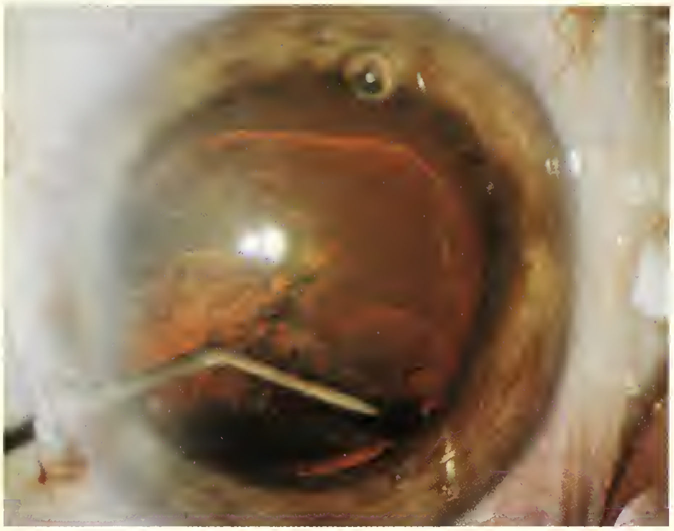

FIGURE 3. Balanced Saline is irrigated under the anterior capsule to separate cortex and nucleus (hydrodisection). Note fluid wave.

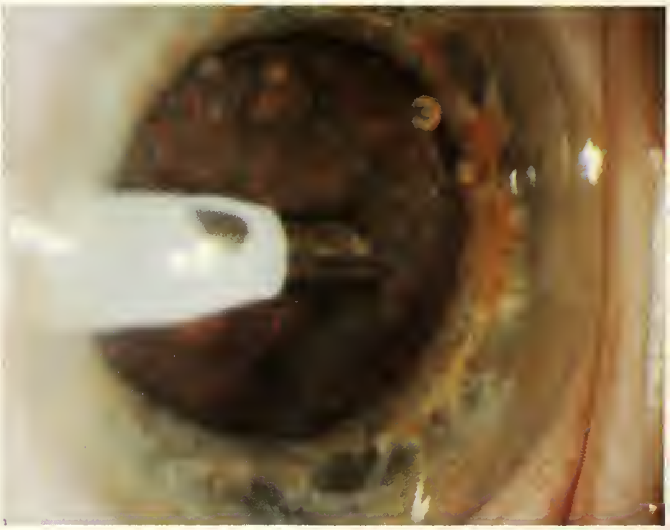

FIGURE 4. Using a 45 degree tip the nucleus is phacoemulsified using a one-handed technique.

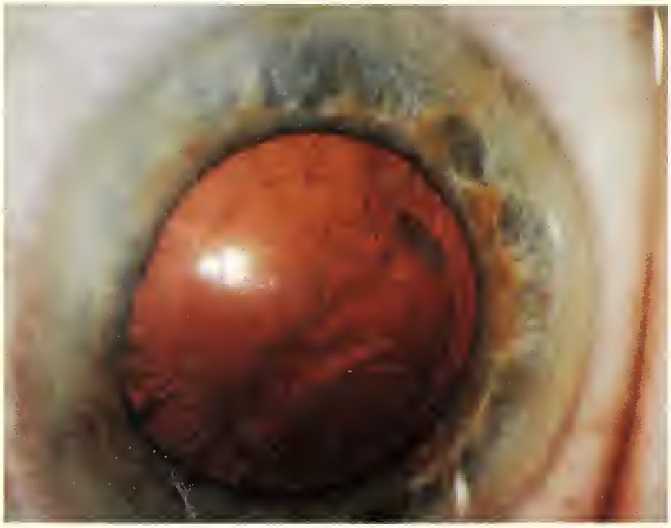

FIGURE 5. After complete removal of the nucleus, strands of cortex remain in the periphery.

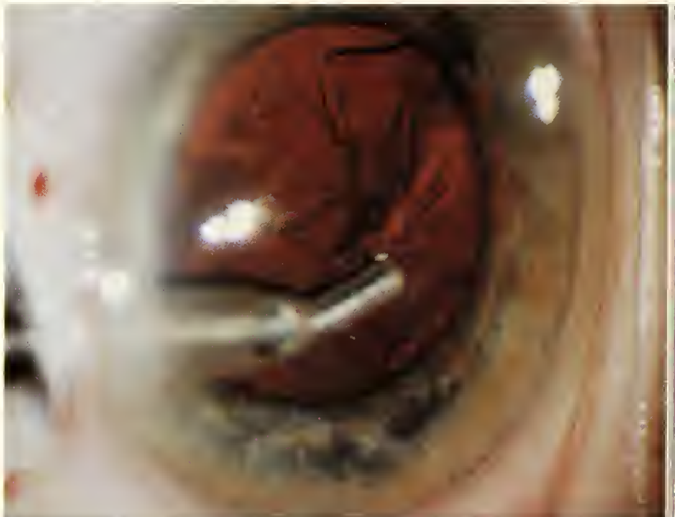

FIGURE 6. Using an irrigation/aspiration tip the cortex is removed.

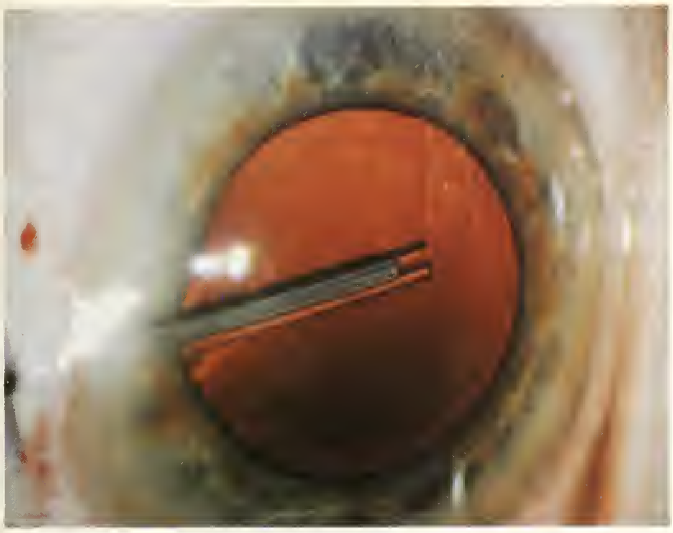

FIGURE 7. The posterior capsule is cleaned with a capsule polisher.

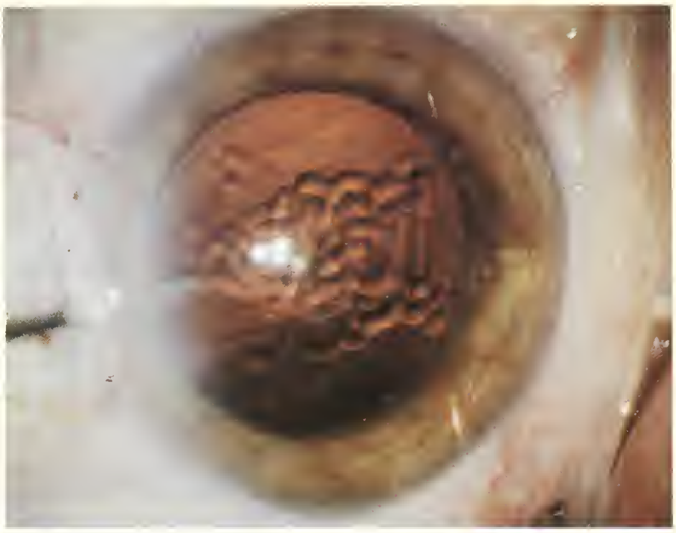

FIGURE 8. Viscoat is injected to inflate the empty capsular bag.

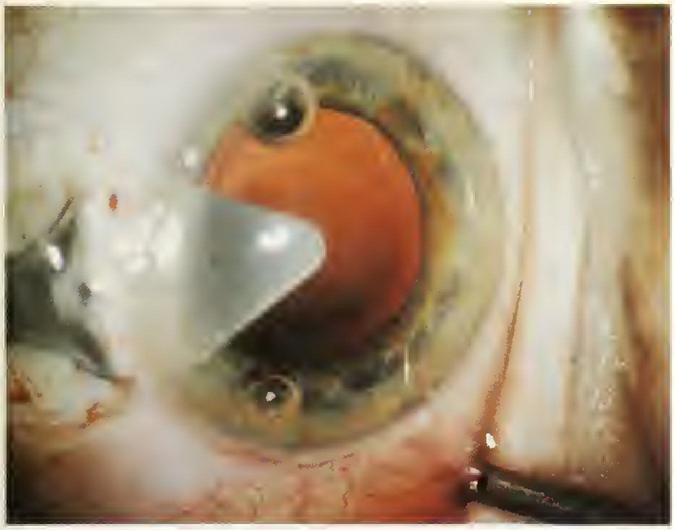

FIGURE 9. The incision is opened to 5.1 mm. Note air bubbles.

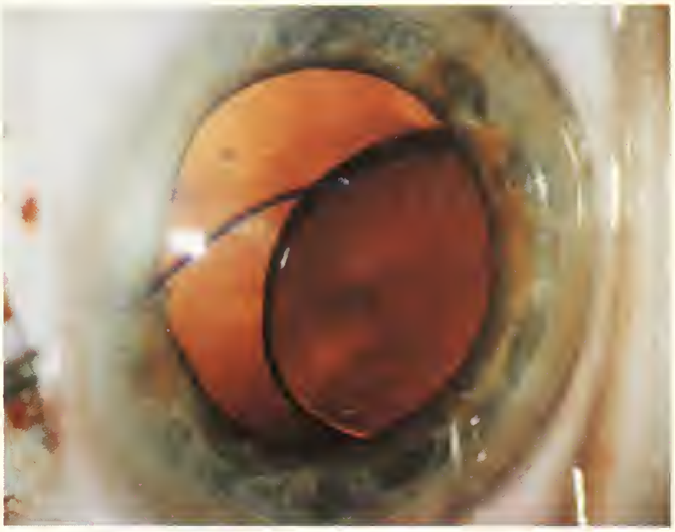

FIGURE 10. The 5x6 mm IOL is placed through the anterior capsular opening into the capsular bag.

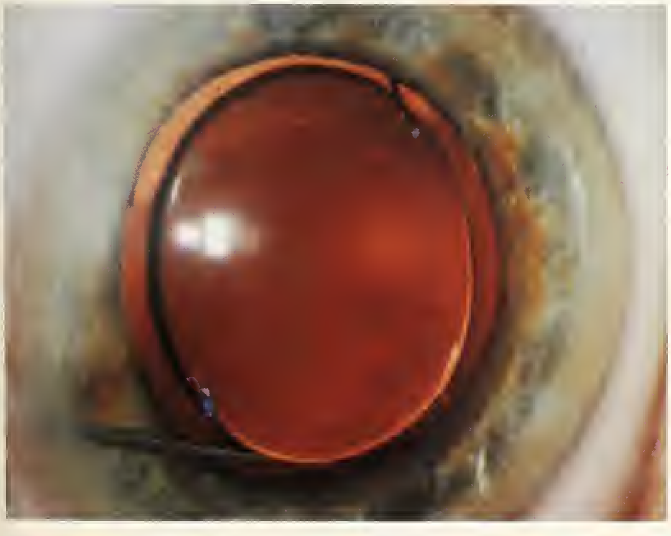

FIGURE 11. The IOL is rotated to a horizontal position. The IOL centers perfectly.

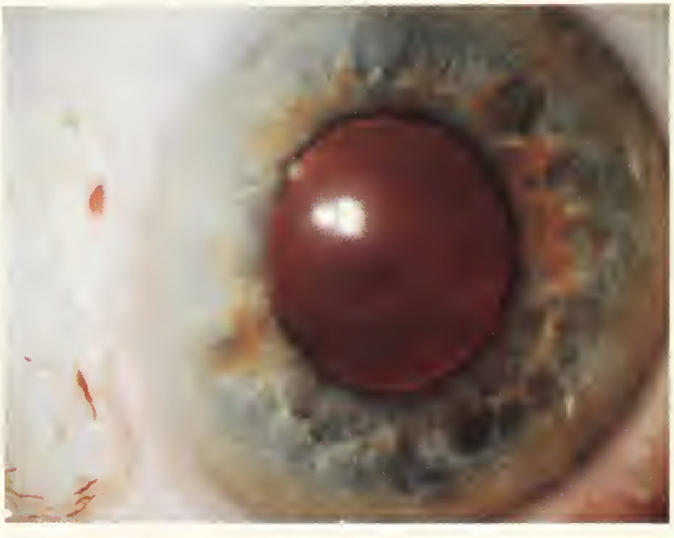

FIGURE 12. The pupil is constricted with Carbacol and the wound closed with a "X" type 10-0 nylon. Wound does not leak even without a suture.

Continued from page 663

Series 10,000 Master phacoemulsifier was used with the 45 degree PHACO tip. The nucleus was removed intercapsularly (Figure 4) with a one-handed Arnold PHACO technique[2]. In very hard lens a two-handed minimal lift technique[3] was used. The cortex was removed (Figure 5 & 6) with the Rhine irrigation/aspiration handle and its interchangeable tips[4]. In difficult cases the 12 o'clock cortex was removed through a side port corneal incision using a cannula[5] of the author's design. The posterior capsule was polished (Figure 7). The capsular bag was filled with Viscoat (Figure 8) and the incision enlarged to 5/1 mm with a keratome (Figure 9). A 5mm by 6mm surface modified, PMMA, 14.00 mm intraocular lens (IOPTEX) with prolene loops was placed in the capsular bag (Figure 10). The IOL was rotated to the horizontal position (Figure 11), Viscoat removed, intracameral carbachol instilled and the wound closed with a single 10-0 nylon "X" type suture or left sutureless (Figure 12). All patients were seen at one day, one week and six week post-operatively. A refraction was done pre-operatively and the second or third visit post-operatively.

RESULTS

A total of 312 cataract/IOL surgeries were performed. Of these 288 (92%) were PHACO. Twenty-three (7%) were ECCE. A single intracapsular cataract extraction by cryoprobe and anterior chamber IOL insertion was done on a traumatically dislocated cataractous lens. One patient was lost to follow-up and one died of a stroke before a post-operative refraction was done. These two patients are omitted from summary. There were no conversions from PHACO to ECCE intraoperatively.

There were two operative complications in the PHACO cases: a capsular tear and vitreous loss occurred with nuclear rotation of a very hard lens and a case of pseudoexfoliation had a zonular dialysis and vitreous loss. No complications occurred during ECCE. The incidence of capsular tear/vitreous loss in the PHACO series was 0.64%. Both patients with operative complications achieved 20/30 final visual acuity. One secondary operation was done, a pars plana vitrectomy and secondary anterior chamber IOL insertion.

The post-operative visual acuities for the PHACO patients are summarized in Table 1. In this series 268 (94%) had 20/40 vision or better. The causes of final vision less than 20/40 in the 18 patients are summarized in Table 2. If patients with known pre-operative retinal/macular pathology are excluded then 99 % of the PHACO patients achieved 20/40 vision or better.

TABLE 1

POST-OPERATIVE VISUAL ACUITY FOLLOWING PHACOEMULSIFICATION

final visual acuity	number	percentage
20/15 to 20/25	199	70
20/30 to 20/40	69	24
20/50 to 20/80	11	4
20/100 to 20/200	7	2
20/400 or worse	0	0
Totals	286	100

DISCUSSION

The first phacoemulsification procedure on a human cataract was done in 1967 by Ophthalmologist/inventor Charles D. Kelman. The operation lasted four and half hours and the ultrasound time was one hour and 19 minutes. (With current instrumentation and techniques operating time is now 15-45 minutes with ultrasound times of one to five minutes!) The procedure culminated his research begun in 1962. The story of how Kelman invented phacoemulsification and the resistance he encountered from the Ophthalmic establishment is the subject of a fascinating book[6]. The operation remains controversial a quarter century after its discovery. The percentage of patients operated on by phacoemulsification is increasing rapidly[7] in the last several years. It is the method of choice of surgeons with large surgical practices.

The advantages of phacoemulsification are considerable: a smaller, stronger, faster healing incision, less post-

TABLE 2

CAUSES OF POST-OPERATIVE VISUAL ACUITY LESS THAN 20/40

diagnosis	number	percentage
macular degradation	7	38.9
previous retinal detachment	2	11.1
corneal disease	2	11.1
amblyopia	2	11.1
retinal vascular disease	1	5.6
diabetic maculopathy	1	5.6
pre-existing macular hole	1	5.6
cystoid macular edema/hole	1	5.6
unknown	1	5.6
Totals	18	100.0

operative inflammation and astigmatism, shorter operating time, and a lower incidence of expulsive hemorrhage. Experienced PHACO surgeons report operative complications and visual acuity statistics[8] as good as or better than ECCE.

Other advantages of PHACO that are difficult to quantitate but readily apparent in the author's opinion are: happier patents who return to full activity almost immediately, more intra-operative control of intra-ocular pressure, faster recovery of vision and better uncorrected vision. The surgeon receives a personal sense of satisfaction for having acquired an additional surgical skill.

The disadvantages of phacoemulsification are the higher monetary costs of the procedure and the increased dependance on sophisticated high maintenance technology. PHACO is a more demanding and complex operation than ECCE and may not be suitable for surgeons with very small surgical practices and/or borderline surgical skills. It is also believed that phacoemulsification has a higher complication rate during the transition period (first 100 cases).

It is not possible for private practice surgeons to acquire the technical skills to do PHACO without total dedication to mastering the procedure, a firm belief that the procedure is superior to ECCE and an acceptance of the increased stress associated with doing an unfamiliar procedure.

During the year prior to this study the author began an intense effort to acquire the technical skills of PHACO. This consisted of attending numerous didactic and laboratory PHACO courses, reading all standard textbooks on phacoemulsification, reviewing the literature, and watching hundreds of videos of PHACO surgery, observing and assisting at live surgery performed by master PHACO surgeons, performing animal eye surgery and surgery on practice synthetic phaco-cataracts (Maloney-Hall System).

The novice PHACO surgeon benefits tremendously from the many excellent PHACO courses now available as well as the dramatic improvement in phacoemulsifiers over those used five to ten years ago.

The author began surgery on humans by doing phacoemulsification on the lens nucleus during ECCE cataract surgery. The amount of the nucleus that the author could emulsify comfortably was gradually increased before switching to an expressive extra-capsular technique. It was also beneficial practicing cortex removal through a three millimeter space marked between sutures during ECCE. PHACO was done initially on only the easiest cases-soft or medium hard nuclei in widely dilated pupils with good exposure and healthy corneas. If any problems were encountered the author switched to the ECCE procedure.

After a year of combined PHACO/ECCE and selective use PHACO the author began the second year using phacoemulsification whenever possible and began this prospective study. Extremely difficult cases (small pupils, hard lens) were done by ECCE. As proficientcy increases with PHACO technique the percentage of patients treated by the ECCE procedure continues to decrease.

This prospective study addressed the complication rate and visual acuity data during transition to phacoemulsification. The results of this study show that PHACO can be introduced into a private practice with an extremely low complication rate and excellent visual results. The complication rates and visual acuity statistics in this study are better than Ophthalmology residents[9] learning PHACO and similar to published[7] results of experienced, nationally known teachers of PHACO.

For most surgeons, phacoemulsification is a superior method of removing cataracts from most patients. It is possible for community surgeons to learn this procedure and safely introduce it into their practices.

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The Author

John C. Hagan III, M.D., is founder and director of the Midwest Eye Institute of Kansas City. He is an ophthalmologist subspecializing in cataract and intraocular implant surgery. During the course of this study he was Vice-Chairman, Department of Surgery, North Kansas City Hospital.

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ESOPHAGEAL STRICTURE: RESULTS OF DILATION OF 300 PATIENTS

by Leslie E. Tucker, M.D.

Three hundred patients underwent 1,177 esophageal dilations over a nine-year period. There were 164 men and 136 women. Mean age was 63 years. Etiology of stricture was peptic (160), Schatzki's ring (124), cancer (8), post-surgical (3), post-radiation (2), caustic ingestion (1), and esophageal web (2). Dilators used were Maloney red-rubber mercury weighted (78.1%), Savary wire-guided (15.2%), Eder-Puestow (6.3%) and Balloon (0.4%). Fluoroscopy was used in 98% of cases. One hundred and two of the 111 patients with peptic strictures observed for longer than six months had successful dilation. Forty-five of these patients (40.5%) required 54 redilations to maintain relief of dysphagia. Nine patients were refractory to dilation, two needing serial dilation and seven surgery. All Schatzki's rings were treated successfully. Ten of 82 patients followed for greater than six months needed redilation (12%). Morbidity was 0.2% with two complications occurring, an esophageal perforation and one case of hematemesis. There was no mortality.

Most esophageal strictures can be managed medically by esophageal dilation.[1,2] Surgery for strictures is needed in only 5 to 15% of cases.[3,4] In this article, we report on esophageal dilation involving 300 consecutive patients. We emphasize the important role of routine fluoroscopy to our low morbidity and lack of mortality.

Methods

A prospective study of 300 patients undergoing esophageal dilation over a nine-year period, September 1982 to January 1992, was done. Maloney dilators were used for simple peptic strictures and Schatzki's rings. Wire-guided dilators were used for complicated strictures (tight strictures with diameter less than 30 French, the tortuous esophagus, presence of multiple esophageal diverticula and the inability to pass a Maloney dilator despite fluoroscopy). All procedures performed after 1983 (98% of total) utilized fluoroscopy. The passage of all Maloney dilators was monitored fluoroscopically by a physician to determine if the dilator would pass unimpeded through the stricture. In some cases, the dilator would impact above the stricture, within a hiatal hernia sac, curl above the stricture or within a hiatal hernia sac, or the widest part of the dilator would fail to traverse the stricture. In these instances, the dilation could usually be successfully accomplished by reorientation of the dilator utilizing fluoroscopic guidance. In some instances, Maloney dilation was still impossible and wire-guided dilation became necessary. The passage of all wire-guided dilators was also monitored by fluoroscopy. Cetacaine throat spray as well as minimal dosage of meperidine (50mg), diazepam (1-2mg) or midazolam (0.5-1.5mg) were given. All Schatzki's rings were dilated to at least a 54 French size. Peptic strictures were dilated to a mean of 53 French. No more than three dilators were passed per session. Strictures were classified as being peptic if esophageal erosions or ulcerations were noted endoscopically or Schatzki's ring (a constriction in the distal esophagus due to a symmetric thin web of fibrotic submucosal thickening).[5]

Eleven hundred and seventy seven dilations were done in 300 patients. Dilators used were Maloney red-rubber mercury weighted dilators (919;78.1%), Savary wire-guided (179;15.2%), Eder-Puestow (74;6.3%), and Thru-the-Scope Balloon dilators (5;0.4%). All patients were followed at yearly intervals. Success was defined as complete resolution of dysphagia, with the patient being able to eat normally.

Results

The patients ranged in age from 11 to 95 years, with a mean age of 63. There were 164 men and 136 women. The etiology of stricture formation was peptic (160), Schatzki's ring (124), cancer (8), post-surgical (3), post-radiation (2), caustic ingestion (1), and upper esophageal web (2). One hundred and two of the 111 patients with peptic strictures (92%) observed for longer than six months had successful dilation as measured by complete resolution of dysphagia.

Forty-five of these patients (40.5%) required 54 redilations to maintain symptom free control. Two patients had frequent stricture recurrence but were not surgical candidates and were managed by serial dilation. Seven patients underwent surgery, one for Barrett's esophagus and refractory stricture necessitating colon interposition, and six for reflux symptoms alone, which were treated with Nissen fundoplication.

All patients with Schatzki's ring were dilated successfully. Ten of eighty-two patients (12%) followed for greater than six months needed redilation. Of these, six needed more than one dilation. Two complications occurred in 1,177 dilations, giving a morbidity of 0.2%. One patient developed an upper esophageal perforation after dilation of a Schatzki's ring with a 50 French Maloney dilator. He was treated with drainage and antibiotics and did well. Another patient with peptic stricture developed hematemesis after passage of a 54 French Maloney dilator. He did not require transfusion. Our single perforation did occur in the absence of fluoroscopy.

Discussion

Our success rate for dilation (92%) and low morbidity (0.2%) compare very well to that reported by others[6,7,8] Reported morbidity for esophageal dilation ranges from 0.2 to 2.2%.[9,10] Most complications are due to perforation and bleeding. Reported rates of perforation range from 0.4 to 8.0%, with an average of 4-6 per 1000 dilations. We experienced our only perforation using a Maloney dilator in the absence of fluoroscopy. We had no complications with the wire-guided dilators. Monnier and Dumon dilated 113 and 163 patients respectively using Savary dilators with perforation rates of 0% and 0.6%.[11,12] We dilated 50 patients with 179 Savary dilators without complication.

Redilation of peptic strictures is common (40%) but easily accomplished. Schatzki's rings needed redilation in only 12% of cases. These results are in sharp contrast to that of Groskreutz and Kim.[13] They reported that 35 of 56 patients (63%) needed redilation. This study was retrospective, successful dilation was not confirmed by fluoroscopy and the mean diameter achieved by dilation (51 versus 54 French) was lower than in our patients. Their higher redilation rate may thus be due to the failure to document successful passage of the dilator, as well as failure to use a dilator of sufficient size.[14] We feel that the routine use of fluoroscopy greatly contributed to our low morbidity and lack of mortality. A recent study by McClave et al reported that the use of fluoroscopy increased the rate of successful dilation from 80% to 96%. Patients dilated blindly were also twice as likely to have an adverse effect from dilation, 5.6% versus 11.2%.[15] Adverse effects would include misdirection of the dilator with subsequent pain, tear with hematemesis, or intubation of the trachea. A recent study by us corroborated these results in that 24% of patients undergoing blind dilation were observed to have misdirection of the dilator when monitored by a fluoroscopist.[16]

In summary, we feel that esophageal dilation can be done safely and effectively. We believe that the use of routine fluoroscopy enhances effective dilation and contributes to fewer complications. Fluoroscopy may not be necessary in those cases where the esophageal anatomy is straight, and no large hiatal hernia is present. Patients who cannot be dilated by Maloney dilators can be done safely with the Savary wire-guided system. Although balloon dilators have a theoretical advantage of applying less shearing force than conventional dilators, a clinical advantage has not been demonstrated.[17,18]

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SKIN EXPANSION AS PREPARATION FOR AN OPENING WEDGE OSTEOTOMY OF THE MID-FOOT IN ARTHROGRYPOSIS

By Norman D. Buebendorf, M.D., Matthew J. Concannon, M.D.,

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A case report is presented in which tissue expansion is used to provide the additional skin needed during an opening wedge mid-foot osteotomy to correct a varus foot deformity in a patient with arthrogryposis multiplex congenita. Tissue expansion is a relatively new method of acquiring coverage for wounds which may have advantages over previous techniques. The risks and drawbacks of this technique will be described in detail.

Coverage in orthopedic surgery is always a problem when opening wedge osteotomies are necessary for extremity realignment. The extra skin needed has traditionally been accomplished with local skin flaps, myocutaneous flaps, distant flaps, and free flaps since a parasitic skin graft may often be inadequate. The advantages of using local tissue are obvious (color, texture, contour, sensation, and simplicity). However, available local tissue may be inadequate in amount.The currently popular technique of tissue expansion, in which a temporary inflatable prostheses is inserted under the skin adjacent to the proposed operative site, may simplify some of these cases. A net gain in skin, as opposed to mere stretching, occurs. It has been shown in numerous studies that skin tolerates this gradual expansion quite well.[2,3,7] This extra tissue may allow comfortable closure even following bone lengthening. The following case of a child with arthrogryposis multiplex congenita illustrates the use of tissue expansion to acquire the extra skin needed during an opening wedge mid-foot osteotomy to correct a varus foot deformity.

CASE REPORT

This patient was a seven-year-old white girl with a history of arthrogryposis multiplex congenita with manifestations confined mainly to the knees, ankles, and feet, and a particularly severe talipes equinovarus deformity. She had undergone previous casting and bilateral posterior medial Achilles tendon releases, as well as one right and two left tibial and fibular derotation osteotomies (Fig. 1 and 2). The patient needed additional surgery to correct mid-foot varus. An opening wedge osteotomy was selected because the parents were adamant about avoiding surgery which would have made the feet significantly unequal in shoe size. Because of medial mid-foot scarring subsequent to her previous posteromedial release skin coverage was a problem. Tissue expansion was felt to be a reasonable alternative to flap transfer to gain the additional coverage needed.

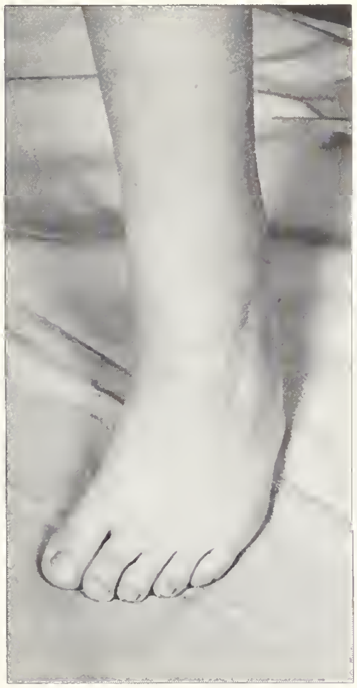

Figure 1. Anterior view of left foot shows varus foot deformity.

Approximately three months prior to the planned orthopedic procedure, the patient was admitted to the outpatient ambulatory surgery unit and under general anesthesia a 50 cc Silastic tissue expander with a remote inflation port was placed in the proximal medial portion of the left foot. The patient returned at weekly intervals following surgery and the expander was inflated to tissue tolerance, or until the patient complained of pain. About eight to ten cc's of normal saline were injected at each session. The patient was permitted weight-bearing on the foot (Fig. 3).

On several occasions, when the suture line looked erythematous, no expansion was done. Sutures were removed at four weeks. Near the end of the expansion period, a two by six mm area of exposed silastic expander was seen in the suture line. Since no frank infection or erythema was noted at this time, expansion was continued to completion, protecting this area with steri-strips. After anesthetic induction at the second (orthopedic) procedure, ten cc's of normal saline were injected causing skin blanching. This overfilling gave a small additional amount of expansion during the few minutes taken to prep and drape the patient.

The incision was made sharply over the original suture line and the subcutaneous tissue was then incised with the cutting cautery to expose the expander. After removal of the intact expander, the injection port was removed with only a small amount of sharp dissection necessary. The expander (which contained nearly 60 cc of normal saline) had provided ample soft tissue for coverage of the bone graft used to correct the deformity in the foot. The patient was discharged five days postoperatively in stable condition and has done well (Fig. 4).

DISCUSSION

Tissue expansion is a relatively new technique, although Newman in 1957 placed an inflatable balloon in the post-auricular area for reconstruction of a traumatically damaged ear.[6] Radovan and Austad in 1975-76, working independently, reintroduced the technique and began research to improve it.[3,8] Tissue expansion today is done with commercially available stock (Fig. 5) or with a custom-made Silastic reservoir with either a remote (connected by a tube) or incorporated valve (placed in the anterior wall of the expander). A multitude of sizes and shapes are available to accommodate the location, shape, and size of the defect. Expanders may be filled to several times their normal volume without risk of rupture. Two separate surgical procedures are necessary, with the intervening period (weeks or months) being used to expand the balloon during clinic visits. At the time of the second and definitive surgery the expander is removed and the expanded "extra" tissue can be used as needed.

TECHNIQUE

The expander is usually placed in the prefascial plane in a pocket created by sharp and blunt dissection. The pocket is usually one to three cm larger than the expander in each direction, and the pocket for the remote inflation port (as used with this patient) is placed in an area where it will be readily palpable and under healthy skin. In an extremity, the expander is usually placed lateral to the wound, since more tissue is available here than from the longitudinal axis. The incision is placed, if possible, at the site indicated by the proposed second surgery. The expander may be sutured in place with the attached tabs to prevent migration, and is then filled with a small amount

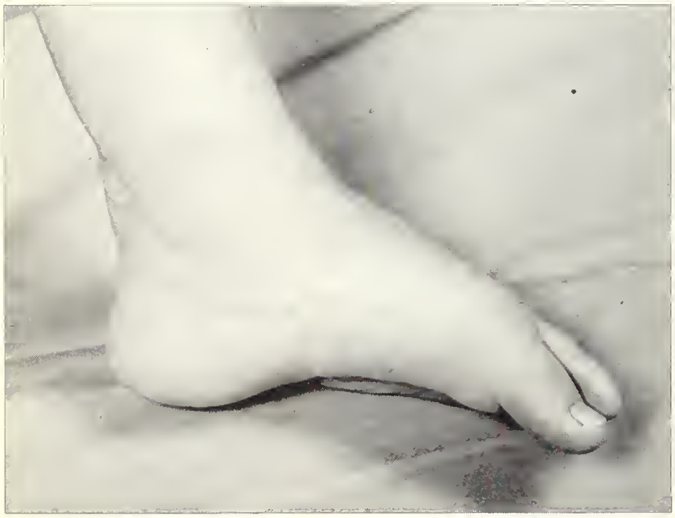

Figure 2. Medial view of left foot show pre-existing surgical scar. (Figures 1 and 2 are both prior to placement of tissue expander.)

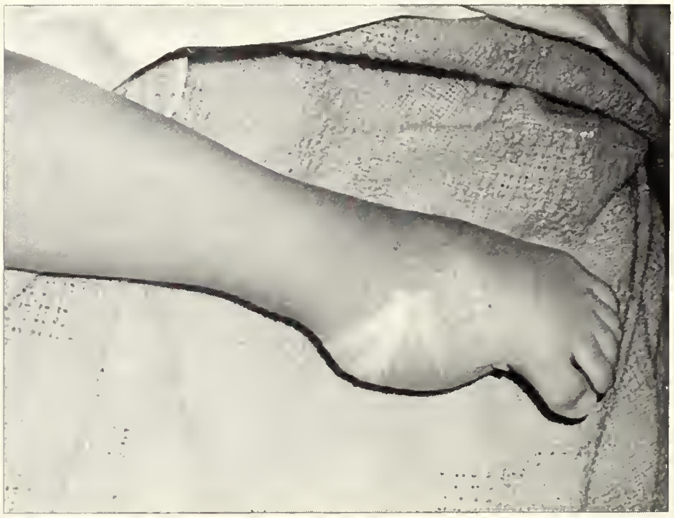

Figure 3. Anterior view of left foot shows full expander in place immediately before second (reconstructive) operation.

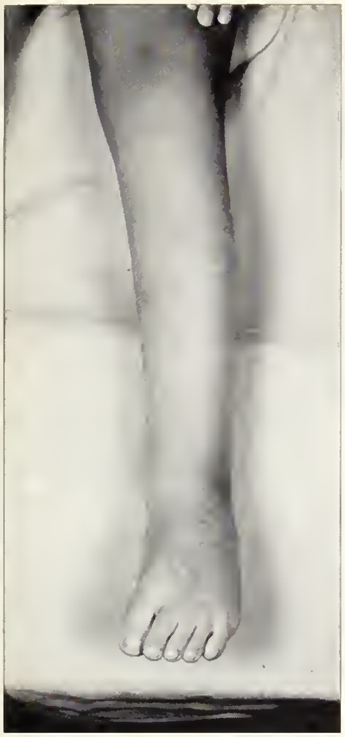

Figure 4. Anterior view of left foot with varus deformity corrected with healthy tissue coverage.

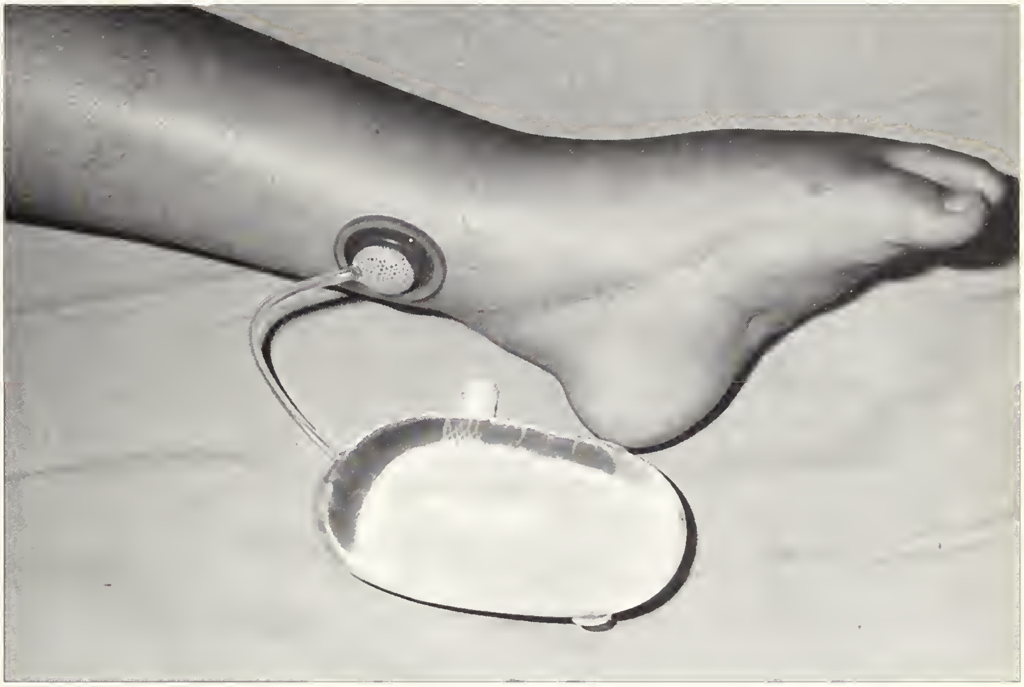

Figure 5. Medial view of foot with illustrative tissue expander in foreground.

of saline and bled of any residual air. After the wound is adequately sealed the expander is inflated at intervals (days or weeks) with sterile technique using normal saline and a 22-25 gauge needle, until enough stretch is obtained. Sasaki (10) has developed a formula for the amount of tissue needed: Tissue Advancement (cm) = 1/2 [length of expanded flap (cm)]

At each clinic visit, the expanders are inflated to a point of patient intolerance or to firmness (but still with capillary refill). The patient is generally permitted normal activity with full range of motion in all joints. Massage of the overlying skin is encouraged and speeds softening.

The expander is overinflated to the point of blanching immediately before surgery (during prepping and draping) as indicated previously. After the expander is removed, hemostasis, while critical, is usually not a problem since a capsule will have formed around the expander. This capsule should not be removed, but may be incised across lines of tension to provide more stretch, if needed. After the underlining orthopedic (or another) procedure is done, the expanded tissue may be tailored to provide as good a closure as possible.

Clinically and experimentally the expansion technique is perceived to act like the delay phenomenon in flaps, resulting in a high quality, well vascularized tissue with excellent viability, which may be safely used to cover soft tissue, bone, or prosthetic materials.[1,4,11]

Although usually unspectacular, complications do arise with this technique. Product failures, although few, can compromise the results and therefore expanders must be examined and tested before insertion. Technical errors due to errant needles during inflation or insertion can result in leaky prostheses requiring replacement. Valves incorporated into the anterior wall the protheses are more prone to this than remote valves. Paletta et al describe the extrusion of an expander five weeks after placement in the lower limb of a 12-month-old child (for coverage of a clubfoot deformity), although they did not speculate the cause of this failure.[13] Atar et al describe the successful expansion of the distal limb (in anticipation of coverage of a clubfoot deformity) in 15-month-old child.[14]

Hematomas and infection constitute the usual operative risks. Skin erosion and extrusion of the expander may require removal if this occurs early, but the situation is often salvageable if these complications happen late in the expansion course, and if no frank infection is present.[1] Inadequate tissue advancement is conceivably a complication, but by proper planning, an adequate number and size of expanders can be employed. The advantages of this technique are many. It provides an excellent quality tissue, similar in color, texture, contour, and sensation without disrupting the adnexal structures. It results in minimal donor site morbidity. In cases of failure, little tissue is lost and therefore further attempts at reconstruction are not made more difficult.[5] The technique is relatively simple, not requiring the specialized skills of microsurgery, or requiring extensive dissections as with many flap coverage techniques. The hospital and recovery time is decreased as is patient expense. This technique does have some drawbacks. The procedure is rather labor intensive, requiring multiple visits and a second surgical procedure for final reconstruction. Depending on location, the temporary deformity with the expander in place can be quite significant and patients may need be fairly clever in their means of concealment. There is often a disconcerting rubescent color to the tissue as it is expanded but this uniformly recedes after removal.

In conclusion, tissue expansion is a relatively new method of acquiring coverage for wounds and surgical sites which may have advantages over some other previous techniques. A typical example case is reported demonstrating the nuances of use.

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FOOD FOR THOUGHT

by Craig S. Holzem, M.D.

The following is a sad but true story about two boys named Tom and Bob. Tom and Bob grew up in a small Missouri town, just south of St. Louis and like many boys their age, were filled with the hopes and dreams of what their futures would be like. Both enjoyed helping others, deciding at an early age to enter the grocery field. After all, what is more important to sustain human life than food? However, this is where the similarity in these two boys ended.

Bob was an average student, did the minimum work required and "got by." Tom, however, was aggressive, took on extra work, and prided himself in being in the top 10% of his class. When high school was over, Bob went on to become a Registered Nutrition Practitioner. It required a minimal amount of training to be able to handle grocery items, didn't require a large investment, and only took a few years to accomplish. Bob realized that he would still need some supervision and that many people might need more exotic foods than he could handle, but these people could be referred to other specialty shops.

Tom reached for loftier goals. After high school, he went to college for four years, earning his bachelor degree of Foodology. Upon graduation, he was about $50,000 in debt. At the same time he could see that his friend Bob was already making a reasonable living, however he could not convince himself what he was the best he could be and therefore decided to continue with his education. Four years later and an additional $50,000 in debt, Tom finally achieved his goal, a doctorate in Foodology. The hours were long, the pace grueling, but there was so much to learn about the special and different food needs of adults, infants, children and the elderly. Tom knew that the only way to be able to understand and take care of all these needs was to continue pushing himself to learn everything possible about food. Tom finally graduated after three years of post-doctorate training, became a board certified grocer, and was ready to meet the people of Missouri head on to help them with their grocery needs.

Tom was good at what he did and enjoyed doing it. He was competitively priced and had a steady flow of customers. Soon, his grocery practice was well established and many people often came by "just to talk." They liked the fact that Tom didn't just treat them like a customer with a number, but was always very pleasant whether asking them about a family member, the local news, or just how life was going in general. People liked Tom's grocery, and as business continued to grow, so did his staff. In a very short period of time he added three more checkers, a stock boy, a bagger, and a business manager. Overall, life was pretty good and there were few complaints.

Tom enjoyed his new career but did not forget his meager beginnings. Often he could be found donating boxes of food to the needy, selling groceries to people on credit (though he was well aware he might never get paid), and even often ignoring shoplifters who stole from his market. He had always wished that there was more he could do for people who couldn't afford food. And then one day he discovered the answer - FOOD STAMPS. What a great idea! The customers who truly needed them could get their stamps from the government, use them in his store, and then he could be reimbursed by the government. What could be more perfect?

Tom began his participation in the food stamp program and initially it worked as planned. The customers would gather up $50 worth of groceries and pay for it with $50 worth of food stamps. Tom would then turn the food stamps into the government and in return would be reimbursed the full $50. The system worked.

This went on for a few years and everyone was happy. Everyone, that is, except the government. It seems that there were more hungry people out there than they had anticipated and so they were spending much more money on food stamps than they had planned. Therefore, the members of congress (many of whom looked like they never missed a meal) decided to save money by cutting back on the amount of the payments they were making to grocers, but did not reduce the value of the stamps issued to the hungry people. After all, grocers make more money than most of their hungry constituents and, in politics, it makes more sense to anger a few voters rather than a lot, doesn't it? The new plan was rather than reimburse the grocer the full amount that had been previously agreed to, they would reimburse him at a rate of about 75 cents to the dollar. They also discovered that if they delayed payment for 90 to 180 days, and reject some of the claims they could save even more money. And thus it was done.

The grocery industry was stunned. Income dropped dramatically and yet even more regulations were added. Small groceries were no longer allowed to test their vegetables for contamination on site unless they were willing to expose themselves to surprise inspections, fees and more regulations. They therefore elected to send them elsewhere for testing, frequently at added expense. OSHA mandated that all employees exposed to pork must be offered the expensive trichinosis vaccine, and that the grocer should pay for it. And as if insurance premiums were not already exceedingly high to begin with, even though Tom won his food poisoning malpractice suit (the litigant later admitted that he had purchased the suspected food from a herbalist), there was little doubt that he would soon see yet another rise in his premium.

But the government wasn't through yet. Since the government was "footing the bill" for this expensive food system, they decided that they needed even more intervention and developed the Produce Review Organization (PRO) to make sure that Tom and other grocers like him were not getting rich off at the government's expense.

The first thing the PRO did was to develop confusing codes, so that many grocers would make mistakes and not be reimbursed at all, or at least at a level lower than what they deserve. For example, how was Tom to know that #616161 "ground beef" carried a weight of only 1.5, but that #161616 "hamburger" carried a weight of 2.0, and would therefore drive the Diet Related Groups (DRGs) at a higher rate of reimbursement. It didn't make much sense that "hot dogs" carried a higher weight than "fillet mignon." Oh well, Tom didn't make the rules, he just has to live (or die) by them.

The second game the PRO developed was "how to deny payment." Tom knew that his customer with high blood pressure and heart failure was supposed to follow a low sodium diet, so when he sold him a bottle of the more expensive low salt gherkins he figured that everything was kosher. The PRO didn't think so. Although the PRO had never met this customer, they decided that they knew other customers like him, and decided that it probably would have been best if the customer had no pickles at all and therefore denied payment.

Just when it looked like it could not get any more ludicrous, it did. One day, while reviewing some of Tom's ever increasing paperwork, the PRO discovered a glaring error. Three months ago, Tom took an order for a side of beef but did not document how it would be sliced. Follow-up documents, that Tom provided after the shipment arrived, describe in full detail how the meat was to be processed, the processing itself, the customer's assessment of how the job was done, as well as Tom's plans for marinating the meat prior to cooking it. Unfortunately, the PRO felt that the issue of processing should have been more thoroughly documented at the time of ordering, and therefore assessed Tom "1 point" for "failure to document." As much as Tom wanted to laugh at this ridiculous system, he knew that he couldn't, because if he accumulated enough of these "points" his grocery license could be revoked.

Government payments continued to decline and Tom was forced to do something he desperately wanted to avoid, raise his prices. He complained to congress but the response was that he could make up the difference by pushing more customers through the checkout lane. The days of actually talking to the customer were over, and as a result of the less personalized and more expensive grocery, many of his paying customers complained and eventually quit coming to his store.

Fewer and fewer of the other grocers in town accepted food stamps and Tom soon became so overwhelmed that he had to quit taking new food stamp customers as well. A few of his regular food stamp customers abused the system, claiming they were entitled to more food than the government was willing to pay for, but he had to put up with these customers for fear of litigation for abandonment or "dumping."

And as always, when things didn't seem like they could get any worse, they did. The government paid even less on the dollar, and then began a "bundling" program. Congress decided that customers should be able to buy a "meal plan" instead of individual food items, and that no matter how different the plan each customer had in mind, or how many changes they made, the cost would remain the same. If someone wanted to barbecue hamburgers (remember, do not code "ground beef"), they would get their charcoal, lighter fluid, meat, sauce, bread, condiments, etc. all for one bundled price. Not only that, if they make their purchase at another store, and then realize that they had forgotten to pick up relish, they can stop by Tom's and he has to give it to them for free, because the other grocer had already been paid for the bundle. Even if the customer gets heartburn from the meat, he can return to Tom's store (within 90 days of course) and get free Alka-Seltzer.

Even Tom's own political organization had buckled under government pressures. When a farmer recently gave Tom a Christmas ham he was told by the American Meat Association that he shouldn't accept gifts from people he does business with because it might be misinterpreted as showing favoritism. Just imagine, a man who has been giving away literally thousands of dollars worth of food each year is now being accused of "selling out" for a $25 ham.

And now the final blow. Some states are concerned about the lack of board certified grocers in rural communities and are considering recommending that Registered Nutrition Practitioners (RNPs) take over the bulk of common grocery needs for individuals in remote locations.

You remember Bob from earlier in the story. He did only what he had to do to get by with minimal education, and it now looks like he may get the bulk of the basic grocery business. His overhead is small, his bills are few, and his responsibility is low. Not only that, but if he makes a mistake it is still the board certified grocer that will ultimately be responsible for paying the cost. Life is good! Better yet, if any grocery need comes up that he can't handle, he'll just send it on to Tom. Right?

Wrong! Tom decided to take early retirement. So did Dan, Mary, Pete, Betty, and Joe, and thousands of other board certified grocers. The fun of being a grocer was quickly diminishing. They were tired of getting up in the middle of the night to check on alarm systems, early in the morning to pick up deliveries and then spend the rest of the day listening to the rumblings of "how easy grocers have it." Board certified grocers are not staying in the business as long, and fewer of them are encouraging their children to follow in their foot steps.

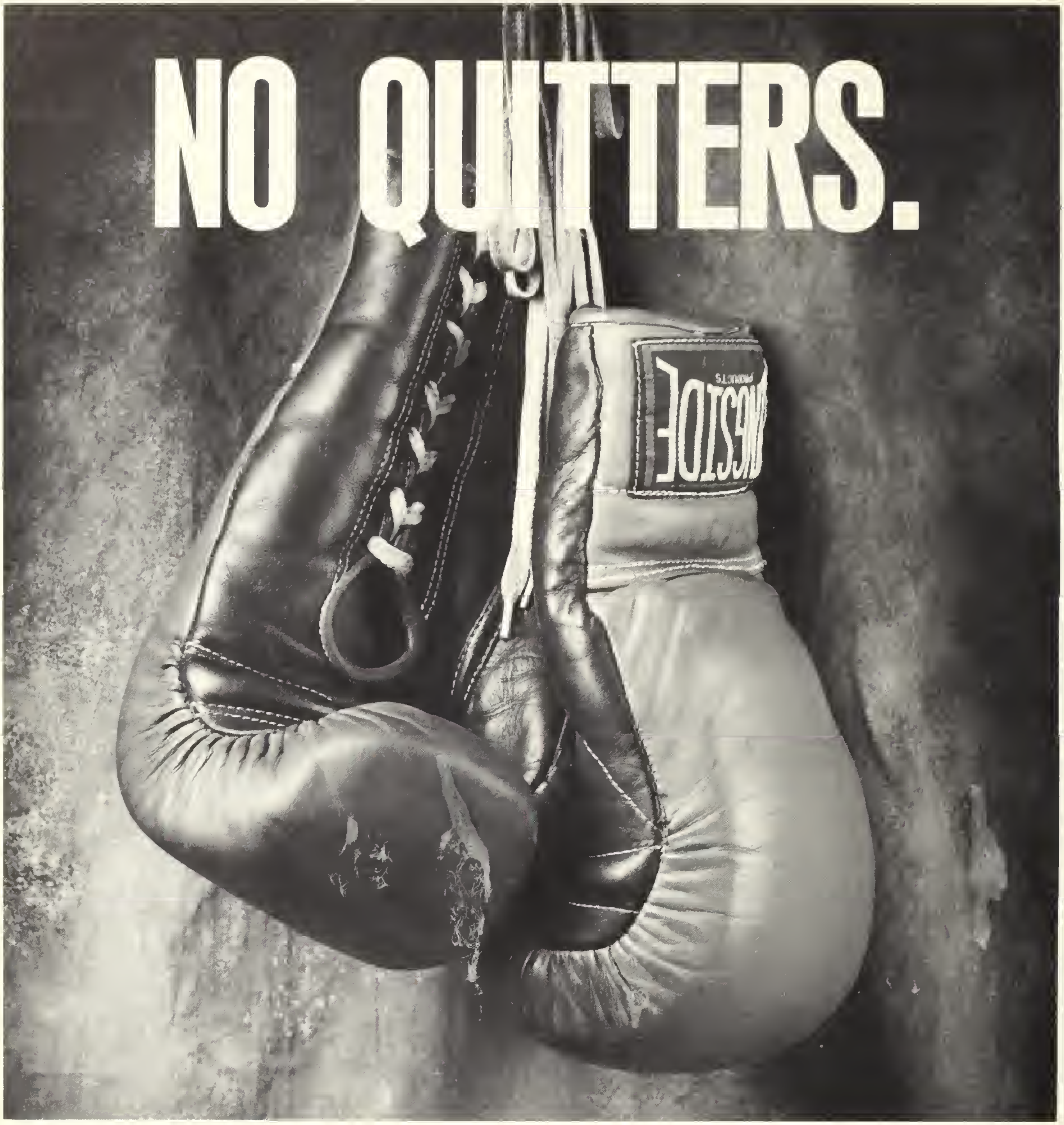
Congress may come up with all kinds of gimmicks to make food more available and affordable to the general population (every one should get free food, shouldn't they?), but if the number of board certified grocers continues to decrease (and that will surely be the case if the current interventionism continues), so will the quality of that food.

As frightening as the preceding story sounds, I have heard rumors that similar changes may be contemplated for the health care system. If the government can so completely destroy a field as vital as food, imagine what utter chaos would be created should they choose to interfere in the complex world of medicine. Then again, maybe I'm just being paranoid. Ours is a world in which a fellow human being may literally live or die based upon the choices that we make. Surely our government will stay out of those decisions. ❐

The author

Craig S. Holzem, MD

Dr. Holzem is a board certified family practitioner currently on staff at the St. John's Mercy Hospital in Washington, MO. In addition to his regular practice, he is medical director of a nursing home and a family practice preceptor for students from the University of Missouri campuses. He received his medical degree from the University of Missouri-Kansas City, and completed his residency at Carswell Air Force Base in Fort Worth, Texas.



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HUMOR IS GOOD MEDICINE

by George M. Bohigian, M.D.

Cheer up! In spite of OSHA regulations, relative value scales systems, rising overhead, and difficult economic times, it may be a good time to look at the humorous side of medicine. Here are some principles by which the profession has survived and will continue to survive.

1. **Loeb's Laws of Medicine:**
    a. If what you're doing is working, keep doing it.
    b. If what you're doing is not working, stop doing it.
    c. If you don't know what to do, don't do anything.
    d. Above all, never let a surgeon get your patient.

2. **Sutton's Law.**
William Dock, M.D., in ward rounds when he discovered that every test had been done except the appropriate one, suggested that the student follow Sutton's Law, which he defined as follows: Willy Sutton, the bank robber, was asked why he always robbed banks rather than hotel clerks, filling stations, or other easy marks. He replied, "Because that's where the money is."

3. **Homer Smith's Law:**
The function of the heart is to pump blood to the kidneys.

4. **Murphy's Laws:**
    a. If it is absolutely impossible for anything to go wrong, it will anyway. Trying to correct it will only make matters worse.
    b. If anything can go wrong, it will.
    c. When anything goes wrong, it does so all at once.
    d. Any error that can creep in, will. It will always be in the direction that will do the most harm.
    e. When left to themselves, things go from bad to worse.
    f. If two things can go wrong, the worst one will happen.
    g. If something goes wrong, it will be at the most inconvenient time.

5. **Parkinson's First Law:**
Work expands to fill the time available for its completion.

6. **The Peter Principle:**
In a hierarchy, employees tend to rise until they reach their level of incompetence.

7. **Gordon's Law:**
If a research project is not worth doing at all, it is not worth doing well.

8. **Pardee's Law:**
There is an inverse relationship between the uniqueness of an observation and the number of investigators who report it simultaneously.

9. **Kunin's Law:**
Garbage equals garbage equals garbage squared (referring to a series of poorly done tests).

10. **Phineas P. Phineagle's Law:**
The more complicated one makes a treatment, the more hopelessly will it become botched.

11. **Rumple's Rule:**
Hospital staff physicians are not totally worthless; they can always be used as horrible examples.

12. **Hawkin's Law for Surgeons:**
The lesser the indication, the greater the complication.

13. **Shumay's Law:**
Bleeding ultimately stops.

14. **Law of Medical Hysteria:**
Inappropriate medical activity is directly proportional to the gravity of the patient's illness and inversely proportional to the likelihood of real or lasting therapeutic benefit.

15. **White's Law:**
When a patient is beyond fifty years of age, one should make at least two diagnoses.

16. **Furthermore:**

    a. Common things occur commonly.
    b. The race may not always be to the swift not the battle to the strong, but it's a good idea to bet that way.
    c. When you hear hoofbeats think of horses, not zebras.

d. Place your bets on uncommon manifestations of common conditions rather than common manifestations of uncommon conditions.

17. **Barach's Rule:**
An Alcoholic is a person who drinks more than his own physician.

18. **Blair's Observation:**
The best laid plans of mice and men are usually about equal.

19. **The Sausage Principle** (e.g. Tort reform):
People who love sausage and respect the law should never watch either being made.

20. **Bohigian's Rule:**
Life is just a chair of bowlies.

21. **Voda's Law:**
The only thing that is constant is change, but change is changing faster than change.

22. **Old Surgeon's Law:**
There are old surgeons and bold surgeons, but not old, bold surgeons.

23. **Kaplan's Law of Research:**
The first time you do an experiment, it usually works. Thereafter, it can't be repeated until you uncover why it worked originally, and you're back to where you started.

24. **Medical Dictionary Terms:**

Barium	What doctors do when treatment fails
Dilate	To live long
Enema	Not a friend
Fester	Quicker
Fibula	Small Lie
Nitrate	Cheaper than day
Node	was aware of
Out Patient	Person who has fainted
Rectum	Dang near killed 'em
Seizure	Roman emperor
Varicose	Located nearby

George M. Bohigian, M.D. is in private practice. He is a delegate from Missouri to the American Medical Association and Clinical Professor of Ophthalmology at Washington University/Barnes Hospital, St. Louis.

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"Without your help I simply could not have made it through medical school."

The Missouri State Medical Foundation - MSMF - was created by the Missouri State Medical Association for the express purpose of giving financial assistance to deserving young Missourians who will be tomorrow's doctors.

Send your check today to the Missouri State Medical Foundation, 113 Madison St., P.O. Box 1028, Jefferson City, MO 65101.

Help for the Impaired Physician

Through its Physicians' Health Committee, MSMA helps doctors who are suffering from alcoholism, other drug addiction, psychiatric disorders, or other illnesses that may impair a physician's judgement and ability to render care.

The goal of the program is to help, not punish. The Committee is made up of physicians who have special expertise in treating the impaired professional. Effective treatment for these illnesses is achieved most easily when the disease is detected early. Family, friends, and associates are urged not to avoid the issue or give misguided sympathy that enables the condition to deteriorate.

Call the Physicians' Confidential 24-hour Line (314-995-4990). Only specially trained personnel will answer or return calls.

The Physician Recognition Award is presented by the Missouri State Medical Association and the American Medical Association to physicians who voluntarily complete 150 hours of continuing medical education within a three-year period. Sixty of the credit hours must be earned in Category 1 programs.

B-W-R-C
John P. Christy, *Poplar Bluff*
Kirby L. Turner, *Poplar Bluff*

Boone
John B. Arthaud, *Columbia*
Thomas R. Highland, *Columbia*
Charles L. Puckett, *Columbia*
Michael F. Kaplan, *Columbia*

Buchanan
J. Douglas Bradley, *St. Joseph*
John S. Crie, *St. Joseph*
Ernest E. Weinand, *St. Joseph*

Cape Girardeau County Area
David J. Westrich, *Cape Girardeau*
Vijaya K. Mangunta, *New Madrid*
Charlie B. Williams, *West Plains*

F-G-W
Ted C. Vargas, *Pacific*

Grand River
William T. Boulware, *Chillicothe*

Greene
James A. Gessler, *Springfield*
Gregory Janeczko, *Springfield*
Wayne B. Miles, *Springfield*
Jimmy C. Presley, *Springfield*

Henry
Richard H. King, *Clinton*
Douglas R. Kenney, *Clinton*

Jasper
John E. Goff, *Joplin*
Paul E. Hilton, *Joplin*

Metro Med of K.C.
Glenn A. Barr, *Kansas City*
Alan E. Bauman, *Kansas City*
Marvin D. Bordy, *Kansas City*
Robert L. Breckenridge, *Kansas City*
William F. Case, *Kansas City*
Stanley Hellerstein, *Kansas City*
Howard W. Kilbride, *Kansas City*
Lynn H. Kindred, *Kansas City*
Larry E. Legler, *Independence*
Michael L. Loren, *Independence*
Alexander G. Mallouk, *Kansas City*
Edwin E. MacGee, *Kansas City*
Ben D. McCallister, *Kansas City*
Janet S. Mertz, *Kansas City*
Turner L. Minnigerode, *Kansas City*
Richard A. Morrison, *Independence*
Ernest H. Neighbor, *Kansas City*
Kim E. Parker, *Kansas City*
Charles B. Porter, *Kansas City*
Walter F. Ricci, *Kansas City*
Bryan L. Sitzmann, *Kansas City*
William D. Soper, *Liberty*
Wilber B. Spalding, *Kansas City*
Alberto Suarez, *Lee's Summit*
Dasari Suseela, *Kansas City*
Suzanne S. Haynes Sword, *Kansas City*
Harvey Thalblum, *Kansas City*
Dan A. Waxman, *Kansas City*
Kathleen M. Williams, *Kansas City*
Paul A. Williams, *Kansas City*
Jerry B. Wurster, *Kansas City*

Mineral Area
Jonathon M. Bird, *Farmington*

Northeast
John A. Memken, *Hannibal*

Northwest
Arturo A. Tenorio, *Stanberry*
Genoveva Tenorio, *Ablany*

St. Louis Metropolitan
Jose Mario V. Alonso, *St. Louis*
Jerome M. Aronberg, *Clayton*
Charles R. Blackwell, *St. Louis*
James P. Boedeker, *St. Louis*
Stephen F. Bowen, *St. Louis*
Enrique Cubillo, *Chesterfield*
James A. Diestelhorst, *St. Louis*
Renee C. Dolan, *St. Louis*
Alan J. Du Montier, *Chesterfield*
Tamara K. Ehlert, *Chesterfield*
Herbert A. Ferrari, *St. Louis*
William B. Gedney, *Valley Park*
William R. Green, *St. Louis*
Abdul G. Khan, *Arnold*
Richard L. Kofkoff, *Bridgeton*
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Daniel H. Lischwe, *Bridgeton*
Timothy R. O'Connell, *St. Louis*
Moududur Rahman, *Clayton*
George O. Sertl, *St. Louis*
Vallee L. Willman, *St. Louis*

SEMO
Jimmy D. Heath, *East Prairie*
Gregorio L. Rodriguez, *Charleston*

DISCIPLINARY ACTIONS

These physicians have received final disciplinary actions from the Missouri State Board of Registration for the Healing Arts. This information is made available to the public under the provisions of Section 334.101 RSMo. Missouri State Medical Association members' names are underlined, the other physicians listed below are not members of the Association.

France Alexander, M.D., St. Louis, MO. Violation of the drug law. Violation: Section 334.100.2(23) RSMo Supp. 1988 and Section 334.100.2(13) RSMo Supp. 1978.
Board Action: Three (3) years probation. Effective 5/7/92.

Frank E. Baum, M.D., Kansas City, MO, Unprofessional and inappropriate conversations of a sexual nature with a patient. Violation: Section 334.100.2(4) RSMo Supp. 1990.
Board Action: License voluntarily surrendered with no reinstatement for seven (7) years. Effective 1/8/92.

Gary Blanchard, M.D., Afton, MO. Chemical dependency. Violation: Section 334.100.2(1), (4)(h), (22) RSMo Supp. 1990.
Board Action: Two (2) years probation. Effective 6/1/92.

William R. Bonner, D.O., Cameron, MO. Violated probation. Violation: Section 334.100.2(4)(d)(h), (6), (10).
Board Action: Six (6) month suspension followed by ten (10) years probation. Effective 6/30/92.

Melvin Burton, M.D., Bridgeton, MO, Allowing a nurse to make medical diagnosis and prescribe medications. Violation: Section 334.100.2(4)(d)(h), (6), (10).
Board Action: One (1) year probation. Effective 12/4/91.

Richard L. Butler, M.D., Alton, IL, Action taken by another state. Violation: Section 334.100.2(8) RSMo Supp. 1988.
Board Action: 1/29/92 - License placed on ten (10) years probation. Effective 8/8/89.

Amy Byer, M.D., Gaithersberg, MD, Action taken by a hospital. Violation: Section 334.100.2(4)(g) RSMo Supp. 1987.
Board Action: Ten (10) years probation. Effective 3/12/92.

Patrick T. Conner, M.D., Springfield, MO.
Board Action: 1/29/92 - Modification allowing limited prescribing granted to 8/6/90 probationary agreement.

Willie S. Cortez, M.D., Lebanon, MO, Violated the Missouri Board's Amphetamine Rule which instructs the doctor not to prescribe more than a 30-day supply of amphetamine agents per prescription. Additionally, Dr. Cortez's prescribing privileges were restricted by BNDD; his staff privileges were suspended on four occasions for failure to maintain adequate medical records; and he was deficient in required continuing medical education hours.
Violation: Section 334.100.2 RSMo
Board Action: 30-day suspension followed by a five (5) year probation. Effective 1/1/92.

Fernando J. Decastro, M.D., St. Louis, MO
Board Action: 3/1/92 - License reinstated under a seven (7) year probation.

Donald C. Edgren, M.D., Cameron, MO
Board Action: 10/1/91 - 2-month suspension followed by a ten (10) year probation for violation of his 7/18/91 probation agreement with the Board by practicing while his licensed was suspended; not notifying practice settings of his disciplinary status, and his failure to renew his license in a timely fashion.

James Ellegood, M.D., Marion, IL, Conviction in U.S. District Court for the Western District of Tennessee of conspiracy to possess with intent to distribute a controlled substance, to wit, 10 kilograms of cocaine and 2400 dosage units of anabolic steroids. Violation: Section 334.103 RSMo.
Board Action: Revocation of Missouri license. Effective 1/3/92.

Richard P. Gardine, D.O., Kirksville, MO. Violated probation. Violation: Section 334.100.2(4)(o)(p), (6), (13) 195.060.1 RSMo Supp. 1990.
Board Action: Seven (7) days suspension and five (5) years probation. Effective 7/6/92.

Joseph Hazan, M.D., Bridgeton, MO. Allowing a nurse to make medical diagnosis and prescribe medications. Violation: Section 334.100.2(4)(d)(h), (6), (10).
Board Action: One (1) year probation. Effective 12/4/91.

Mumatata Nataraj Kasal, M.D., Columbia, MO
Board Action: 1/27/92 - Temporary license issued on a probationary status wherein she will not apply for renewal or reinstatement of a temporary license to practice in Missouri after the expiration of this agreement.

John W. Klema, Jr., D.O., Kansas City, MO.
Board Action: Probation terminated. Effective 5/5/92.

Aloysius Kush, D.O., Wyalusing, PA.
Board Action: Probation terminated. Effective 6/1/92.

Walter J. Kutryb, M.D., St. Louis, MO, 12/30/91 - Retirement agreement signed in lieu of further investigations or proceedings concerning his license to practice.

John R. Lefevre, D.O., Flint, MI, Personal impairment. Violation: Section 334.100.2(4) RSMo Supp. 1990.
Board Action: Placed on five (5) years probation. Effective 8/23/91.

Napoleon Maminta, M.D., Clarkson Valley, MO. Violated probation; appealed revocation. Violation: Section 334.100.2(4)(a)(o), (12), (17) RSMo Supp. 1987.
Board Action: Revocation reinstated. Effective 4/9/92.

Alvaro Mora-Perez, M.D., Bridgeton, MO. Allowing a nurse to make medical diagnosis and prescribe medications. Violation: Section 334.100.2(4)(d)(h), (6), (10).
Board Action: One (1) year probation. Effective 12/4/91.

Bruce S. Pugatch, M.D., St. Louis, MO.
Probation terminated. Effective 7/1/92.

Gordon H. Robinson, M.D., St. Louis, MO, Unprofessional conduct. Violation: Section 334.100.2(4)(g).
Board Action: Formal Reprimand. Effective 3/9/92.

Ernest C. Rose, M.D., Poplar Bluff, MO,
Probation terminated. Effective 7/9/92.

William O. Seabaugh, M.D., Cape Girardeau, MO, 10/14/91 - Mandatory retirement as part of 2/10/89 probation agreement.

Cesar Villanueva, M.D., Kansas City, MO
Board Action: Termination of probation. Effective 2/19/92.

Mary C. Weibel, M.D., Belgium. Allowing a person who is not qualified to make medical diagnosis and prescribe medication to do so. Violation: Section 334.100.2(5), (6), (10), (13) RSMo Supp. 1986; Section 334.100.2(4)(d)(h), (6), (10), (13) RSMo Supp. 1987.
Board Action: Two (2) weeks suspension to be followed by five (5) years probation. Effective 12/3/91.

Nancy J. Welsh, M.D., Topeka, KS.
Probation terminated. Effective 5/5/92.

David White, M.D., Lake Ozark, MO, Personal impairment. Violation: Section 334.100.2(4a)(6)(13)(22) RSMo
Board Action: 1-week suspension followed by a five (5) year probation. Effective 10/11/91.

John Williams, M.D., St. Louis, MO, Allowing a nurse to make medical diagnosis and prescribe medications. Violation: Section 334.100.2(4)(d)(h), (6), (10).
Board Action: One (1) year probation. Effective 12/4/91.

David Yahnke, M.D., Tulsa, OK, Personal impairment. Violation: Section 334.100.2(8) RSMo Supp. 1990.
Board Action: License issued on three (3) year probation. Effective 12/20/91.

Frederick Zahn, M.D., St. Louis, MO, Conviction of a Class C felony of assault in the second degree, the felony of armed criminal action, and the Class D felony of unlawful use of a weapon. Violation: Section 334.103 RSMo
Board Action: Revocation of Missouri license. Effective 12/12/91.

Health Access America

The AMA proposal to improve access to affordable, quality health care.

"I can't afford to go to the doctor."

We hear that a lot from our patients these days. For the 33 million people who have no health insurance, it's a particularly acute problem.

That's why the AMA has launched a proposal to improve access to affordable, quality health care. It's called *Health Access America*. The message is being sent to Congress, the media, labor and management organizations, concerned groups like AARP, and your fellow physicians.

Simply, *Health Access America* proposes health insurance coverage for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

America's physicians are leading the way to reforming the health care system by speaking out on these critical issues.

To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

The American Medical Association
on behalf of member physicians and their patients.

A message from The American Medical Association for the Health Access America Proposal

MSMA-RPS, What's in it for me?

It probably comes as no surprise that the time demands of a residency program make the "traditional" channels of entry into local and state medical societies difficult. The MSMA-RPS was established in 1989 to facilitate Missouri's 1,106 resident physicians into full MSMA participation.

The development of the MSMA-RPS has it roots in the 1960s and 70s, when the AMA recognized the needs and interests of resident physicians for national representation. This interest resulted in the creation of an AMA Committee on Housestaff Affairs, which soon became the Intern and Resident Business Section of the AMA. In 1974, the IRBS became the AMA Resident Physicians Section.

Its original goals were threefold: 1) To educate residents about national health care issues and graduate medical education; 2) To develop a truly representative organization for residents; and 3) To train young leaders.

The AMA-RPS accomplishes these goals primarily through state medical society resident physicians sections, such as the MSMA-RPS.

The minimum investment for residents in the MSMA-RPS is minimal (the price of dues); the rewards, substantial. Here are just a few:

Continued membership. Physicians that join organized medicine early in their careers tend to be active in organized medicine throughout their careers. In fact, AMA Department of Membership statistics show that almost three times as many residents who are members of RPS remain regular members in their respective state medical societies once residency is completed.

Individual leadership. Leadership positions within the MSMA-RPS can serve as an ideal training ground for leadership positions throughout a physician's career, such as at the hospital, community, and specialty levels, as well as local, state, and national medical society levels.

Political representation. Your MSMA-RPS dues help support lobbying efforts to support the concerns of resident physicians in the halls of Washington, DC, as well as Jefferson City.

Special products and services. Materials supplied by AMA and MSMA can provide valuable service and educational tools for resident physician education and career planning.

The MSMA has a genuine interest in responding to the needs of Missouri's resident physicians. Contact the MSMA at 1-800-869-MSMA for further information on how **you** can serve the MSMA, and how the MSMA can help serve **your** needs.

Interested in knowing what the Resident Physicians section of the AMA has been doing for you? Here is a summary of actions undertaken by the AMA-RPS at the June meeting in Chicago:

RESOLUTIONS

Resolutions adopted by the AMA-RPS included topics such as:

- **Opposition to court-ordered castration**
- **Working with state licensing boards to eliminate "across the board" questions regarding psychotherapy and/or psychiatric treatment**
- **Attempting to add "sexual orientation" to the nondiscrimination policy statement in the AMA Policy Compendium**
- **The use of rank-order balloting for AMA-RPS elections**
- **Proper use of in-service exams by program directors**
- **Expanding the role of the resident and the student member on the AMA's Council of Ethical & Judicial Affairs**

Items referred to the AMA-RPS Governing Council dealt with a similar variety of topics, including:

- **Setting guidelines for admission to medical school for individuals with disabilities**
- **Studying the dual classification of residents as "employees" by the IRS for tax purposes, and as "students" by the National Labor Relations Board**
- **Changing the structure of awards for the AMA "Member Get A Member" program**
- **Studying the impact of cost effectiveness of physician services in relation to the total cost of health care**
- **Expansion of the National Health Services Corp**
- **Congress' breach of student loan contracts in regards to recent changes in deferment of loans**
- **Opposition to random urine drug screening of VA physicians in situations other than preemployment examinations, reasonable suspicion of drug-related performance impairment, and monitoring as part of a comprehensive rehabilitation program.**

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.
Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.
Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.
Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]
Dosage and Administration: Experimental dosage reported in treatment of erectile Impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]
How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.
References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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By S.D. Madduri, M.D.

In the deep depths of the kidney
At the apex of the renal papilla
In the darkness of a microconduit
Crystals of calcium
Crystals of oxalate
And crystals of uric acid
Join together and a STONE is born

The stone that causes excruciating pain
As it tears through the ureter
Stone that changes the life of its host
As he suffers the agony of colic
Stone more expensive than diamond
And billions more in lost wages

Techniques ingenious and imaginative
Man invented to fight the 'damn' stone
Stone baskets, Ultrasonics
Laser beams and Ureteroscopes
All sent to 'get' the stone
Lithotriptors and their bath tubs
With those 'shock waves' to disintegrate the stone

Yet, the stone eludes all efforts
And makes its presence felt like stubborn Saddam
The pain that wakes up the host at midnight
The excruciating colic that tears through the guts
The intense nausea that incapacitates
An experience cannot be forgotten
Makes man feel humble and helpless
At the whims of the mighty stone

NEW MEMBERS

❖ **W. Stuart Adams, M.D.,** 125 Dunn Rd., Florissant, MO 63031, has become a member of the Missouri State Medical Association. Dr. Adams received his medical degree at the University of Missouri, Columbia, MO, in 1989. He completed his residency at the University of Virginia, Charlottesville, VA. Dr. Adams specializes in pediatrics.

❖ **Susan R. Adams, M.D.,** 125 Dunn Rd., Florissant, MO 63031, has become a member of the Missouri State Medical Association. Dr. Adams received her medical degree at the University of Missouri, Columbia, MO, in 1989. She completed her residency at the University of Virginia, Charlottesville, VA. Dr. Adams specializes in internal medicine.

❖ **George A. Aydelott, M.D.,** 1443 N. Robberson, Suite 208, Springfield, MO 65802, has become a member of the Greene County Medical Society. Dr. Aydelott received his medical degree at the University of Illinois, Peoria, IL, in 1978. He completed his residency at the University of Arkansas, Little Rock, AR. Dr. Aydelott specializes in Diagnostic Radiology.

❖ **David J. Anderson, M.D.,** 621 S. New Ballas Rd., St. Louis, MO 63141, has become a member of the St. Louis Metropolitan Medical Society. Dr. Anderson received his medical degree at St. Louis University Medical School, St. Louis, MO, in 1983. He completed his fellowship at St. Louis Shriners Hospital for Crippled Children. Dr. Anderson specializes in orthopedics.

❖ **David B. Bock, M.D.,** 6650 Troost, Suite 206, Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Bock received his medical degree at the University of Oklahoma, Oklahoma City, OK, in 1985. He completed his residency at Methodist Medical Center, Dallas, TX. Dr. Bock specializes in urology.

❖ **Walter D. Branch, M.D.,** Suite 232, 6400 Prospect, Kansas City, MO 64132, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Branch received his medical degree at the Medical University of South Carolina, Charleston, SC, in 1979. He completed his residency at Pontiac General Hospital, Pontiac, MI. Dr. Branch specializes in general surgery.

❖ **Karmel L. Carothers, M.D.,** 1515 W. Truman Blvd., Ste. 709, Independence, MO 64050, has become a member of the Missouri State Medical Association. Dr. Carothers received her medical degree at the University of Kansas, Kansas City, KS, in 1989. She completed her residency at the Medical College of Wisconsin, Milwaukee, WI. Dr. Carothers specializes in internal medicine.

❖ **Sreenadha R. Davuluri, M.D.,** 3105 Frederick, Suite C, St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Davuluri received his medical degree at Osmania Medical College, Hyderabad, Andhra Pradesh, India, in 1970. He completed his residency at the VA Medical Center, Brooklyn, NY. Dr. Davuluri specializes in neurology.

❖ **Zhivko Daskalov, M.D.,** 600 E. 22nd Street, Kansas City, MO 64108, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Daskalov received his medical degree at the Academy of Medicine, Sofia, Bulgaria, in 1955. He completed his residency at Western Missouri Mental Health Center, Kansas City, MO. Dr. Daskalov specializes in psychiatry.

❖ **Sidney S. Devins, M.D.,** 6700 Troost #224, Kansas City, MO 64131, has become a member of the Missouri State Medical Association. Dr. Devins received his medical degree at the University of Missouri-Kansas City, Kansas City, MO, in 1985. He completed his residency at Washington University School of Medicine, St. Louis, MO. Dr. Devins specializes in pulmonary medicine.

❖ **Craig E. Downs, D.O.,** 1235 E. Cherokee, Springfield, MO 65804, has become a member of the Greene County Medical Society. Dr. Downs received his osteopathic degree at Michigan State University College of Osteopathic Medicine, East Lansing, MI, in 1975. He completed his residency at University Hospital of Jacksonville, FL. Dr. Downs specializes in pediatrics.

❖ **Gerald L. Early, M.D.,** 5301 Foraon St., St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Early received his medical degree at the University of Missouri-Kansas City, Kansas City, MO, in 1973. He completed his residency at Ohio State University, Columbus, OH. Dr. Early specializes in cardiovascular and thoracic surgery.

❖ **William P. Gibson, M.D.,** St. Luke's Hospital, 232 S. Woods Mill Rd., Chesterfield, MO 63017, has become a member of the St. Louis Metropolitan Medical Society. Dr. received his medical degree at the University of Arkansas, Little Rock, AR, in 1974. He completed his fellowship at Harvard Medical School, Boston, MA. Dr. Gibson specializes in anesthesiology.

❖ **Kendra J. Guernsey, M.D.,** 1700 Rainbow Blvd., Excelsior Springs, MO, has become a member of the Missouri State Medical Association. Dr. Guernsey received her medical degree at Hahnemann Medical College of Philadelphia, PA, in 1977. She completed her residency at the University of Cincinnati, OH. Dr. Guernsey specializes in anesthesiology.

Continued from page 687

❖ **Robert D. Hartley, II, M.D.,** 11155 Dunn Rd., Ste. 303E, St. Louis, MO 63136, has become a member of the St. Louis Metropolitan Medical Society. Dr. Hartley received his medical degree at the University of Kansas Medical Center, Kansas City, KS, in 1966. He completed his residency at the University of Colorado Medical Center, Denver, CO. Dr. Hartley specializes in pediatrics.

❖ **Leonard W. Hess, M.D.,** University of Missouri Medical Center, Dept. of OB/GYN, N613, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Hess received his medical degree at the Medical College of Virginia, Richmond, VA, in 1977. He completed his residency at the United States Naval Hospital, Portsmouth, VA. Dr. Hess specializes in obstetrics/gynecology.

❖ **Douglas W. Hughes, M.D.,** 8900 Indian Creek Pkwy #450, Overland Park, KS 66210, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Hughes received his medical degree at the University of Oklahoma, Oklahoma City, OK. He completed his residency at the University of Kansas, Kansas City, KS. Dr. Hughes specializes in radiology.

❖ **Cecilia C. Hsu, M.D.,** Suite 510, 10550 Quivira Rd., Overland Park, KS 66215, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Hsu received his medical degree at the National Taiwan University, Taipei, Taiwan, in 1973. She completed her residency at Overlook Hospital, Summit, NJ. Dr. Hsu specializes in pediatrics.

❖ **Glen E. Johnson, M.D.,** has become a member of the St. Louis Metropolitan Medical Society. Dr. Johnson received his medical degree at West Virginia University, Morgantown, WV, in 1985. He completed his fellowship at Methodist Sports Medicine Center/Methodist Hospital, Indianapolis, IN. Dr. Johnson specializes in orthopedics.

❖ **Vincent G. Johnson, D.O.,** 1800 E. Meyer Blvd., Kansas City, MO 64132, has become a member of the Missouri State Medical Association. Dr. Johnson received his osteopathic degree at the University of Health Sciences, Kansas City, MO, in 1983. He completed his residency at Wilford Hall USAF Medical Center, San Antonio, TX. Dr. Johnson specializes in anesthesiology.

❖ **Jeffrey T. Joyce, M.D.,** 1001 E. 101st Ter., Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Joyce received his medical degree at the University of Kansas Medical Center, Kansas City, KS, in 1977. He completed his residency at St. Luke's Hospital, Kansas City, MO, and fellowship at the University of California, San Francisco, CA. Dr. Joyce specializes in anesthesiology.

❖ **Spencer W. Kerley, M.D.,** 7800 West 110th St., Overland Park, KS 66210, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Kerley received his medical degree at the University of Kansas School of Medicine, Kansas City, KS, in 1990. He completed his fellowship at the Mayo Clinic, Rochester, MN. Dr. Kerley specializes in pathology.

❖ **Janet S. Kinney, M.D.,** Neonatology Department, 2401 Gillham Rd., Kansas City, MO 64108, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Kinney received her medical degree at Duke University School of Medicine, Durham, NC, in 1980. She completed her fellowship at Johns Hopkins School of Medicine, Baltimore, MD and Children's Mercy Hospital, Kansas City, MO. Dr. Kinney specializes in neonatology/pediatric infectious diseases.

❖ **Kent I. Kossoy, M.D.,** 6400 Clayton Rd. #107, St. Louis, MO 63117, has become a member of the St. Louis Metropolitan Medical Society. Dr. Kossoy received his medical degree at the University of Missouri, Columbia, MO, in 1985. He completed his residency at the University of Texas, Houston, TX. Dr. Kossoy specializes in colorectal general surgery.

❖ **Susan E. Mackinnon, M.D.,** Washington University, Dept. of Plastic Surgery, One Barnes Hospital, Plaza #17424 E. Pav., St. Louis, MO 63110, has become a member of the St. Louis Metropolitan Medical Society. Dr. Mackinnon received her medical degree at Queen's University, Kingston, Ontario, Canada, in 1975. She completed her fellowship at the University of Toronto, Toronto, Ontario. Dr. Mackinnon specializes in plastic surgery.

❖ **Joseph E. McCullough, M.D.,** Suite 5600, 4321 Washington Street, Kansas City, MO 64111, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. McCullough received his medical degree at Vanderbilt

University, Nashville, TN, in 1984. He completed his fellowship at the Mayo Clinic, Rochester, MN. Dr. McCullough specializes in gastroenterology and hepatology.

❖ **Ted A. McMurry, M.D.,** 1235 E. Cherokee, Springfield, MO 65804, has become a member of the Greene County Medical Society. Dr. McMurry received his medical degree at the University of New Mexico, Albuquerque, NM, in 1979. He completed his residency at the Madigan Army Medical Center, Tacoma, WA. Dr. McMurry specializes in emergency medicine.

❖ **Sidi Y. Noor, M.D.,** Ste. Genevieve Medical Group, Hospital Lane/Center Dr., St. Genevieve, MO 63670, has become a member of the St. Genevieve County Medical Society. Dr. Noor received his medical degree at Rush Medical College, Chicago, IL, in 1983. He completed his residency at West Jersey Hospital, Vorhees, NJ. Dr. Noor specializes in family practice.

❖ **Michelle L. Pal, M.D.,** St. Luke's Hospital, 44th & Wornall, Kansas City, MO 64111, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Pal received her medical degree at the University of Missouri-Kansas City, Kansas City, MO, in 1985. She completed her residency at Baylor University Medical Center, Dallas, TX. Dr. Pal specializes in radiology.

❖ **Keith G. Rasmussen, M.D.,** Washington University, Dept. of Psychiatry, 4940 Audubon Ave., St. Louis, MO 63110, has become a member of the St. Louis Metropolitan Medical Society. Dr. Rasmussen received his medical degree at the Medical College of Virginia, Richmond, VA, in 1987. He completed his residency at the Chicago Medical School, North Chicago, IL. Dr. Rasmussen specializes in psychiatry.

❖ **Rebecca L. Roberts, D.O.,** 802 Faraon St., St. Joseph, MO 64501, has become a member of the Buchanan County Medical Society. Dr. Roberts received her osteopathic degree at the University Health Sciences College, Kansas City, MO, in 1984. Dr. Roberts specializes in emergency medicine.

❖ **Shauna R. Roberts, M.D.,** 5301 Faraon St., St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Roberts received her medical degree at the University of Missouri-Kansas City, Kansas City, MO, in 1984. She completed her residency at the University of Tennesse, Memphis, TN. Dr. Roberts specializes in cardiovascular and thoracic surgery.

❖ **Ann M. Romaker, M.D.,** Suite 5100, 4321 Washington St., Kansas City, MO 64111, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Romaker received her medical degree at the University of Michigan Medical School, Ann Arbor, MI, in 1978. She completed her fellowship at the University of California, San Diego, CA. Dr. Romaker specializes in pulmonary medicine.

❖ **Eleanor Shaheen, M.D.,** Dept. of Child Health, N708 Health Science Center, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Shaheen received her medical degree at the University of Pennsylvania, Philadelphia, PA, in 1950. She completed her residency at the University of Pennsylvania. Dr. Shaheen specializes in behavioral/developmental pediatrics.

❖ **Mark L. Silen, M.D.,** 1465 S. Grand Blvd., GH521, St. Louis 63104, has become a member of the St. Louis Metropolitan Medical Society. Dr. Silen received his medical degree at Harvard Medical School, Boston, MA, in 1980. He completed his residency at Babies Hospital, NY. Dr. Silen specializes in pediatric surgery.

❖ **Stephen L. Stoops, M.D.,** 1001 E. 101st Terr., Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Stoops received his medical degree at the University of Kansas Medical Center, Kansas City, KS, in 1982. He completed his residency at the University of Washington Teaching Hospital, Seattle, WA. Dr. Stoops specializes in anesthesiology.

❖ **Jesse G. Susi, M.D.,** 1035 Bellevue, Suite 102, St. Louis, MO 63117, has become a member of the St. Louis Metropolitan Medical Society. Dr. Susi received his medical degree at St. Louis University School of Medicine, St. Louis, MO, in 1979. He completed his residency at St. Louis University Group Hospital. Dr. Susi specializes in orthopedic surgery.

❖ **Walter S. Trombold, M.D.,** Suite 201, 6650 Troost, Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Trombold received his medical degree at the University of Kansas, Kansas City, KS, in 1974. He completed his fellowship at the University of Utah College of Medicine University Hospital, Salt Lake City, UT. Dr. Trombold specializes in internal medicine and pulmonary disease.

Continued on page 690

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Continued from page 689

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Sudhir S. Batchu, M.D., *Neurology*
Jane R. Brady, M.D., *Obstetrics/Gynecology*
Jodianne T. Carter, *Internal Medicine*
J. Douglas Cusick, M.D., *Plastic Surgery*
Kevin R. Eck, M.D., *General Surgery*
Gilda A. Gross, M.D., *Obstetrics/Gynecology*
Jon F. Hillyer, M.D., *Internal Medicine*
Ralph C. Imlay, M.D., *Internal Medicine*
Charlotte J. Kennedy, M.D., *Internal Medicine*
Maurice L. King, M.D., *Emergency Medicine*
Francis F. Lachowsky, M.D., *Internal Medicine*
Mary E. Mani, M.D., *Obstetrics/Gynecology*
Sammy L. Page, M.D., *Internal Medicine*
William S. Pauls, M.D., *Emergency Medicine*
Victorija L. Smith, M.D., *General Surgery*
Robert B. Strimling, M.D., *Dermatology*
V. Reid Sutton, M.D., *Pediatrics*
Jerome E. Thurman, M.D., *Internal Medicine*
Anthony A. Tze, M.D., *Internal Medicine*
Thomas R. Whalen, M.D., *Obstetrics/Gynecology*
Anthony M. Zelazny, M.D., *Diagnostic Radiology*
Mark S. Zobel, M.D., *Radiology*

Students

St. Louis University
Barbara R. Ferdman
Cherie A. Le Fevre
Marc A. Luckett

University of Missouri-Columbia
Heidi K. Chua
Jane E. Guenther
Jennifer A. LaBarge
Jerome J. Mank
Michael G. Maurizi
John D. Miles
John C. Mruzik
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Joseph E. Prince
Anthony G. Richmond
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Paula Stuebben
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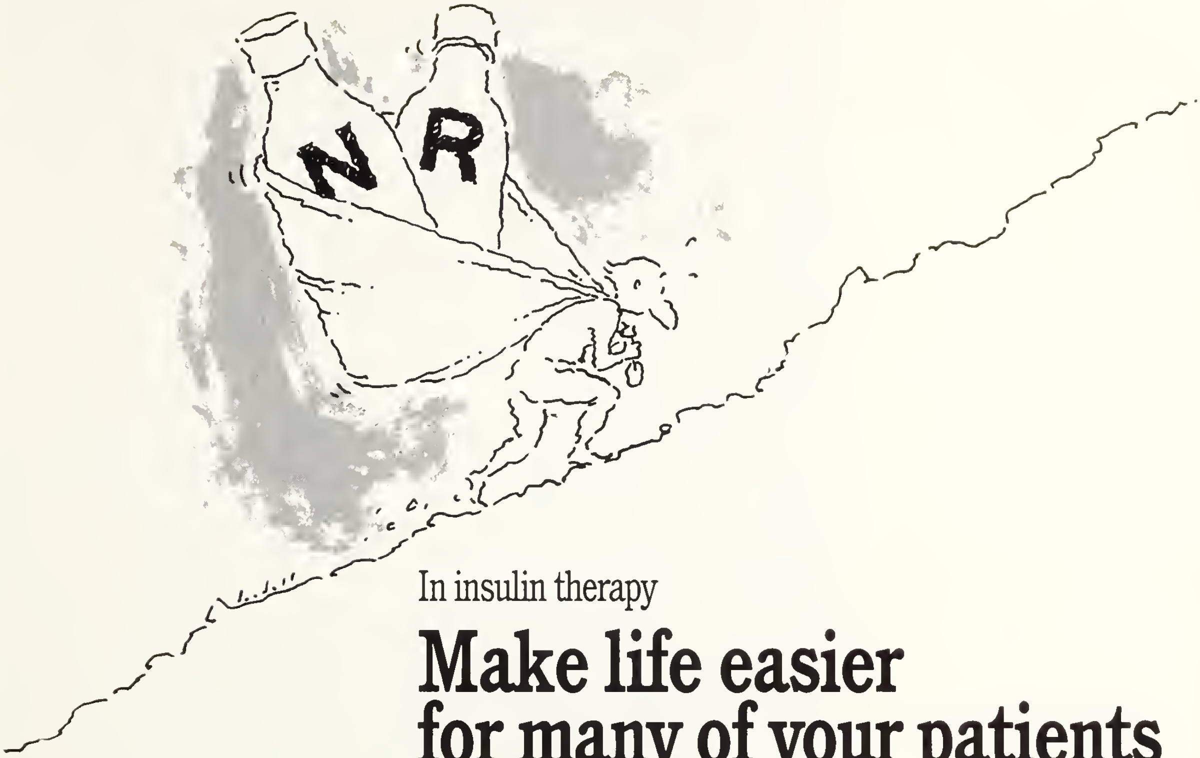
Deanna R. Willis



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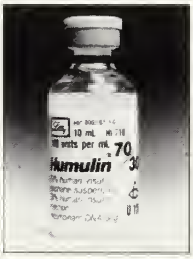

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■ **Frederick B. Campbell, M.D.,** Overland Park, KS, died June 26, 1992 at age 97. Dr. Campbell received his medical degree at the University of Kansas Medical School in 1918. He practiced in Kansas City as a colon and rectal surgeon from 1920 until retirement in 1977. Dr. Campbell was former staff president of General Hospital, where he served as a consultant for 28 years and founded the colon and rectal clinic. He also was former staff president at Research Medical Center and St. Mary's Hospital, and on staff at St. Luke's Hospital. Dr. Campbell was a fellow of the American and International colleges of surgeons and a fellow and past president of the American Society of Colon and Rectal Surgeons. He was a past president of the Jackson County Medical Society and a member of the Missouri State Medical and American Medical Associations.

■ **Donald J. Dickler, M.D.,** Clayton, died May 19, 1992 at age 71. Dr. Dickler received his medical degree at New York University in 1945. He became a faculty member of Washington University, and director of the Department of Anesthesiology at Jewish Hospital in 1957. After retirement in 1989 he remained active in the training program at Jewish Hospital. He achieved national prominence for his work in pain control and for his use of intravenous xylocaine as a general anesthetic. Dr. Dickler was a founding member of the St. Louis Society of Anesthesiologists and a past president of the Missouri Society of Anesthesiologists. He was a charter member of the New York State Society of Anesthesiologists, a member of the American Society and a diplomat of the American Board of Anesthesiology.

■ **Robert H. Fitzgerald, M.D.,** Kansas City, died May 11, 1992 at age 87. Dr. Fitzgerald received his medical degree at St. Louis University School of Medicine in 1931. He practiced general medicine in Leadville, Colorado from 1934 to 1943. He began practice in Kansas City from 1948 until retirement in 1976. Dr. Fitzgerald was formerly chief of surgery at Research Medical Center and chairman of the medical-professional advisory board of the United Cerebral Palsy Association of Greater Kansas City. He was a member of the American Academy of Orthopaedic Surgeons, the American Academy for Cerebral Palsy, the Mid-Central States Orthopaedic Society, the Missouri State Orthopedic Association, the Metropolitan Medical Society of Greater Kansas City, the Missouri State Medical and American Medical Associations.

■ **Anthony C. Hooper, M.D.,** St. Louis, died July 3, 1992 at age 47. Dr. Hooper received his medical degree at the University of Arkansas. He joined the staff of the University of Arkansas as an assistant professor of radiology. Dr. Hooper came to St. Louis in 1980 to work for Ernst Radiology at St. Joseph Hospital of Kirkwood.

■ **Edward C. Kienzle, M.D.,** St. Louis, died June 15, 1992 at age 77. Dr. Kienzle received his medical degree at St. Louis University School of Medicine in 1939. He was in private practice in St. Louis for 40 years and was on staff at Lutheran Hospital in south St. Louis for 38 years. He was also briefly on staff at Alexian Brothers and St. Anthony's Hospitals. Dr. Kienzle was a fellow and past president of the St. Louis Chapter of the American Academy of Family Physicians.

■ **Robert J. Rothweiler, M.D.,** Chesterfield, died May 28, 1992 at age 71. Dr. Rothweiler received his medical degree at St. Louis University School of Medicine in 1946. He was in private practice for nearly 40 years and on staff at St. John's Mercy Medical Center since 1958. He was also an instructor in Otolaryngology at St. Louis University Medical School in the 1950s. He was honored for 25 years of service by Cardinal Glennon Children's Hospital. Dr. Rothweiler was a member of the American Academy of Ophthalmology and Otolaryngology, St. Louis Medical Society, Missouri State Medical and American Medical Associations.

■ **Herbert H. Siesener, M.D.,** St. Louis, died July 4, 1992 at age 72. Dr. Siesener received his medical degree at St. Louis University School of Medicine in 1945. He practiced internal medicine at his office in St. Louis until retirement in 1989. Dr. Siesener was also on staff at St. John's Mercy Medical Center. He was a member of the American College of Physicians.

■ **Charles B. Wilkinson, M.D.,** Kansas City, died June 21, 1992 at age 70. Dr. Wilkinson received his medical degree at Howard University College of Medicine, Washington D.C., in 1944. He received master's degree in psychiatry at the University of Colorado Medical Center in 1949. He taught in the Howard University neuropsychiatry department from 1950 to 1955. He joined the Greater Kansas City Mental Health Foundation's Psychiatric Receiving Center in 1959 and was director of the foundation from 1969 to 1989. He served as associate professor at the University of Missouri-Columbia and was a founder of the University of Missouri-Kansas City School of Medicine. He was also past chairman of the psychiatry department, assistant dean for curriculum and associate dean for development at UMKC. He was a former regional psychiatrist for the F AA and served on the Missouri Advisory Council on Alcoholism and Drug Abuse and the national advisory council to the National Health Institute of Mental Health. He was a former director of the American Board of Psychiatry and Neurology. He was past president of the National Medical Association's section of neuropsychiatry. He was a former trustee and treasurer of the American Psychiatric Association. He was past president of the Black Psychiatrists of America. He was former director and treasurer of the Group for the Advancement of Psychiatry. He was a member of the Academy of Psychoanalysis, American Group Therapy Association and the American Medical and Missouri State Medical Associations.

University of Missouri - Columbia

William C. Allen, M.D., professor emeritus of family and community medicine, is the 1992 recipient of the M. Graham Clark Award, the highest honor given by the Missouri Affiliate of the American Heart Association. The award recognizes a volunteer or staff member who has demonstrated outstanding leadership and dedication to the AHA mission. Dr. Allen has been an AHA volunteer for more than 30 years. As director of the Missouri Department of Health's Section on Chronic Disease and as a member of the AHA Heart Disease in the Young Committee, he was a leader in the program that put an end to rheumatic fever in Missouri. He has served the AHA on all levels and was the affiliate president from 1984 to 1986.

Scott Campbell, Ph.D., assistant professor of cardiology, gave a presentation on myocardial collagen during a symposium at the recent annual scientific session of the International Society for Heart Research in Burlington, VA.

Gordon Christensen, M.D., professor of infectious diseases, recently spoke on staphylococcus epidermis at a symposium in Lund, Sweden, and at the Seventh International Symposium of Staphylococci and Staphylococcal Infections in Stockholm, Sweden.

John Gehrke, M.D., Clinical instructor of orthopedic surgery, has been awarded a grant from the Orthopedic Research and Education Foundation for his osteosaroma research.

Javad Kashani, M.D., professor of child psychiatry, recently was honored as an "exemplary psychiatrist" by the National Alliance for the Mentally Ill.

Karl Kruse, director of the Missouri Kidney Program, received one of two outstanding service awards recently from the End Stage Renal Disease Network 12, which serves, Missouri, Kansas, Iowa and Nebraska. In addition to directing the MU program, Kruse has been active with the National Organization for State Kidney Programs and edited the Directory of State Kidney Programs.

Edith Mitchell, M.D., associate director and interim director of hematology and oncology, has received a grant award from Ciba-Geigy to participate in three protocols testing the agent Aredia in the treatment of multiple myeloma and breast cancer.

Janet Parker, M.D., research investigator with the Dalton Research Center, recently was awarded a National Institutes of Health grant to study coronary occlusion.

Larry Penney, M.D., associate professor of obstetrics and gynecology, has been appointed to an endowed professorship. Penney succeeds Professor William Griffen, M.D., who retired Aug. 31, as the David G. Hall Professor of Obstetrics and Gynecology. The award honors Hall, who served as chairman of the department from 1960 to 1987.

Sandra L. Peterson, Ph.D., assistant professor of anatomy and neurobiology, received a grant from the National Institutes of Health for her research on ovarian hormone regulation.

C. Lin Puckett, M.D., professor and chief of plastic surgery, is the new chairman elect of American Board of Plastic Surgery. Puckett, who chaired the certifying examination for the board in 1991-1992, will take office as chairman in April. The board is the body that administers certifying exams for plastic surgery.

Gregory Renner, M.D., associate professor of otolaryngology, recently was selected to receive the Professorship Grant in Clinical Oncology from the Missouri division of American Cancer Society. The award is renewable annually over five years.

Zbylut Twardowski, M.D., Ph.D., gave presentations on peritoneal dialysis catheters at the Eighth Argentine Congress of Nephrology meeting in Mar del Plata, Argentina.

Karl T. Weber, M.D., chairman of internal medicine and director of cardiology, recently gave a presentation on myocardial tissue in left ventricular hypotrophy at the scientific meeting of the International Society of Hypertension meeting in Madrid, Spain. At the meeting Weber also co-chaired a symposium on the "Evolving Role of Aldosterone in Hypertension: Rationale for Combined Antialdosterone and Diuretic Therapy." Dr. Weber chaired and organized a symposium titled, "Cardiac Interstitum and Its Contribution to Myocardial Failure" at the annual scientific session of the International Society for Heart Research in Burlington, VT.

Washington University

John Atkinson, M.D., has been named chairman of the Department of Internal Medicine. The new appointment, effective October 1, replaces **David M. Kipnis, M.D.,** professor of medicine, who has held the position since 1973. Dr. Kipnis has been appointed Distinguished University Professor of Medicine and will divide future activities between research efforts and special projects. Dr. Atkinson, professor of medicine and molecular microbiology, will leave his position as director of the rheumatology division.

Marcus E. Raichle, M.D., professor of neurology and radiology, is one of 50 new members elected to the Institute of Medicine of the National Academy of Sciences.

Members are elected by the incumbent membership on the basis of professional achievement and demonstrated interest, concern and involvement with problems and critical issues affecting the public health. Dr. Raichle is a pioneer in using positron emission tomography (PET) to map areas of the brain used in specific tasks such as seeing, hearing and speaking.

Milton Schlesing, Ph.D., became named chairman of the Executive Council of the Division of Biology and Biomedical Sciences in July. It is a new position developed from a reorganization of the division's governing structure and replaces the position of director of the division. Former director, Philip Stahl, Ph.D., continues as professor and head of the Department of Cell Biology and Physiology.

Washington University School of Medicine has received a five-year collaborative agreement with Sphinx Pharmaceuticals Corp. to develop new treatments for cardiovascular and inflammatory diseases.

Richard Gross, M.D., Ph.D., professor of medicine, chemistry, and of molecular biology and pharmacology will lead the project. Research will focus on developing therapeutic drugs to control phospholipases A_2 (PLA_2) enzymes thought to play a key role in heart attack, stroke, atherosclerosis, arthritis, asthma and other diseases.

The dermatology division of Washington University School of Medicine has opened an outpatient facility to treat severe cases of psoriasis. Barnes West Dermatology Center specializes in intensive psoriasis therapy that involves the Goeckerman method using tar and ultraviolet light.

A four-year study of diabetic patients has found that anti-depressant drugs can successfully treat clinical depression in diabetic patients. Diabetic patients metabolize some drugs differently than those with normal blood glucose levels. The study of patients with poor glucose control and major depressive disorder, found that diabetic patients receiving the anti-depressant drug nortiriptyline for eight weeks were significantly less depressed than those who received a placebo.

Linda B. Cottler, Ph.D., and **Wilson M. Compton III, M.D.,** co-authored the a new study of the relation between drug abuse and posttraumatic stress disorder (PTSD), as known as "battle fatigue" or "shell shock." It is the first study to look at the question of which problem comes first. Their finding goes against conventional belief that PTSD leads to drug abuse.

The study compared traumas of both the drug-using and non-using populations. Drug users are statistically more likely than the general population both to experience a traumatic event, such as a violent physical attack, and to develop PTSD following the event. Also, the use of more addictive drugs such as cocaine or heroin, had higher rates of PTSD.

The study used data gathered during the Epidemiologic Catchment Area (ECA) study conducted in St. Louis and other sites in 1982-83. Preliminary data from an ongoing study, the Efforts to Reduce the Spread of AIDS (ERSA) study, show PTSD's prevalence is increasing.

Research lead by **Michael G. Caparon, Ph.D.,** assistant professor of molecular microbiology, has found that group A streptococci use protein F to grip to cells when attacting to the throat. This is the first discovery of a genuine streptococcal adherence protein.

Dr. Caparon's research will now advance to the molecular level, using the allelic replacement technique to determine the importance of the protein to the bacterium. It is hoped protein F's discovery will give scientists a better chance at designing a new class of drugs to stop strep adhesion.

Members

David Glover, MD, Warrensburg, above left, newly installed MAFP president and Mark Kasten, MD, Cape Girardeau, chairman of the board.

David W. Glover, M.D., has been installed 44th President of The Missouri Academy of Family Physicians. Dr. Glover received his medical degree at the University of Missouri-Kansas City School of Medicine in 1978. He completed his family practice residency at Baptist Memorial Hospital,

Continued from page 695

Kansas City. Dr. Glover practices at the Warrensburg Family Care Center. He has also held the positions of Secretary-Treasurer, Vice President and President-Elect for MAFP. Dr. Glover has been team physician for the Warrensburg High School Football team and for all Central Missouri State University teams. He has served as Chief of the Medical Staff and Chief of the Department of Family Practice at the Western Missouri Medical Center where he has been a staff member for nine years. Dr. Glover is also a preceptor for the departments of family practice and community medicine at both UMKC and MU.

Thomas M. Macdonnell, M.D., was honored in special recognition ceremonies for his 35 years of membership in the Missouri Academy of Family Physicians. He also received special recognition for his contribution of time, as a physician, while serving as State Representative from the 140th District at the State Capitol. Dr. Macdonnell, third generation physician, has provided health care for individuals and families in Marshfield for 38 years. He has served as a preceptor for the MU department of family and community medicine since 1958.

Dr. "Tommy" Macdonnell, Marshfield, left receives a plaque for his service as a physician at the State Capital from president David Glover, MD.

David W. Hall, M.D., Springfield, was also honored by MAFP for his 35 years of membership. Dr. Hall has been an active member of the MAFP having held all offices including President and Chairman of the Board. He continues to serve as Chairman of the Exhibits Committee and acts as liaison to the Board from the Missouri State Medical Association.

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September

9 to 11 - *St. Louis*: Pediatric Advanced Cardiac & Trauma Support & Pediatric Advanced Life Support Provider Course. 20 credit hours. Contact Mary Beth Foerstel, R.N., St. University Medical Center, 314/577-5385.

11 - *St. Louis:* Pediatric Neurology Update. 7 credit hours. Contact CME Office, St. Louis University Medical Center, 314/577-8167.

11 - *Kansas City:* Hoeper Seminar, Primary Care. 5 1/2 credit hours. Contact The Ed Bixby Institute for Postgraduate Medical Education, 9103 E. 39th St., Kansas City, MO 64133, 816/276-4306, in Missouri, 800/92-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.

11 & 12 - *St. Louis*: Update in Diabetes & Endocrinology for the Primary Care Physician. 11.25 credit hours. Contact Linda Mahn, St. Louis University Medical Center, 577-8458.

12 & 13 - *Columbia*: 2nd Annual Caring for the Frail Elderly. Contact Barry Kling, University of Missouri-Columbia School of Medicine, CME Office, MA215 Health Sciences Center, 314/882-4105.

14 - *St. Louis*: Interventional Neuroradiology. City-Wide Radiology Conference by DeWitte T. Cross, III, M.D. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

15 to 17 - *St. Louis*: Doppler Echocardiography: The Quantitative Approach. 20 credit hours. Contact Dianne Reid, St. Louis University Medical Center, 314/577-8897.

16 to 18 - *St. Louis*: Myocardial Perfusion Imaging in the 1990's. 14 credit hours. Contact CME Office, St. Louis University School of Medicine, 1402 S. Grand Blvd., St. Louis, MO 63104-1083, 314/577-8167 or 800/553-2712.

19 - *St. Louis*: Prostate Diseases: Benign and Malignant. 4 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

19 - *St. Louis*: Gastoenterology Update. 6 credit hours. Contact CME Office, St. Louis University Medical Center, 314/577-8167.

19 - *St. Louis:* Cornea & Contact Lens Update 1992. 8 credit hours. Contact CME Office, St. Louis University Medical Center, 314/577-8167.

19 - *St. Louis*: Current Challenges and Controversies in Arthritis Treatment. 3.5 credit hours. Contact CME Office, St. Louis University School of Medicine, 1402 S. Grand Blvd., St. Louis, MO 63104-1083, 314/577-8167.

21 & 22 - *Kansas City*: Cardiovascular Nursing: The Patient and the Profession. Contact Janet Kennedy, CME, St. Luke's Hospital of Kansas City, 44th and Wornall, Kansas City, MO 64111, 816/932-2220.

21 to 23 - *St. Louis*: Symposium on Aging, Immunity, and Infection. Contact the Conference Secretary, VA Medical Center, GRECC (111G-JB), St. Louis, MO 63125, FTS 280-6510 or 314/894-6510.

24 - *St. Louis*: Fifth Annual Trauma Care Conference. 6.5 credit hours. Contact St. John's Mercy Medical Center, 615 S. New Ballas Rd., St. Louis, MO 63141-8277, 314/569-6290.

25 & 26 - *St. Louis*: Physician Executive Leadership: An Introduction to Medical Administration. 11.75 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

25 to 27 - *St. Joesph*: Advanced Cardiac Life Support Provider Course. 22 credit hours. Contatct Barb Tunks, R.N., Heartland Health System Critical Care Educator, 801 Faraon, St. Joesph, MO 64501, 816/271-7859.

25 to 27 - *St. Louis*: Practical Anatomy & Surgical Workshop: Microsurgery of the Lumbar and Cervial Spine. 19 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

26 - *St. Louis*: Update in Gastroenterology & Hepatology for the Primary Care Physician. 4.5 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

29 & 30 - *St. Louis*: 3rd Annual Spinal Cord Injury Symposium. 14 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

30 to Oct. 2 - *St. Louis*: Contemporary Cardiothoracic Surgery: General Thoracic Transplantation, Cardiovascular. 20.75 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893, 800/325-9862 Interstate.

October

2 - *Kansas City*: Cancer Care Issues and Advances in the 1990's. Contact The Cancer Institute of Kansas City, 816/751-2929, or The Ed Bixby Institute for Postgraduate Medical Education, 9103 E. 39th St., Kansas City, MO 64133, 816/276-4306, in Missouri, 800/92-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.

2 & 3 - *St. Louis*: Update in Ophthalmology. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

2 & 3 - *St. Louis*: Occupational Allergic & Immunologic Disease. 9.5 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

2 to 4 - *Kansas City*: "Doctor Are You Healing or Dealing?" Contact the Missouri Association of Osteopathic Physicians & Surgeons, P.O. Box 748, Jefferson City, MO 65102. PH. 314/634-3415.

Continued on page 698

Continued from page 697

3 - *Kansas City*: **Fourth Annual Surgical Symposium.** Jointly sponsored with Truman Medical Center. 4 Category 1 credit hours. Contact Carol Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.
3 - *St. Louis*: **Isolation of Human Hematopoietic Stem Cells, Stem Cell Expansion, and New Application of Growth Factors.** 6 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.
5 - *St. Louis*: **Images of the Mind: A Vision for Radiology.** Wendell G. Scott Lecture by Marcus E. Raichle, M.D. For more information contact the Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110.
5 to 9 - *St. Louis*: **The Medicolegal Death Investigator Training Course.** 33 credit hours. Contact Mary Fran Ernst, St. Louis University School of Medicine, at 522-6410 ext. 6509.
7 to 10 - *Kansas City*: **Issues in Minority Health Care.** Contact Barry Kling, University of Missouri-Columbia School of Medicine, CME Office, MA215 Health Sciences Center, 314/882-4105.
8 & 9 - *Tulsa, OK*: **Depression: Phenomenology, Etiology and Treatment.** Presented by the Laureate Psychiatric Clinic and Hospital. For more information call 800/322-5173 ext. 4094.
8 to 10 - *Columbia*: **35th Physicians Alumni Weekend.** Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.
Medicine, CME Office, MA215 Health Sciences Center, 314/882-4105.
9 - *Kansas City*: **Office Based Ultrasound for OB/GYN.** 6 credit hours. Contact Carl Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.
9 - *Kansas City*: **Challenges and Controversies in Emergency Care.** Contact the Ed Bixby Institute for Postgraduate Medical Education, 9103 E. 39th St., Kansas City, MO 64133, 816/276-4306, in Missouri, 800/92-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.
13 & 14 - *St. Louis*: **Transesophageal Echocardiography Course.** 13 credit hours. Contact Dianne Reid, St. Louis University Medical Center, 314/577-8897.
15 - *St. Louis*: **Pediatric Advanced Cardiac & Trauma Support & Pediatric Advanced Life Support Recert.** Course. 7 credit hours. Contact the CME Office, St. University Medical Center, 314/577-5385.
15 - *St. Louis*: **Smoking Cessation in the Primary Care Practice.** 5.5 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.
15 to 19 - *Kansas City*. **Protect Your Medical Practice: Effective Management of Abusable Medications.** Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.
16 & 17 - *St. Louis*: **Repetitive Injuries in the Workplace: Prevention, Management, ADA.** 10.25 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.
17 - *St. Louis*: **Midwest Clinical - Molecular Cardiology Conference.** 8.25 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.
23 to 24 - *Kansas City*: **Lasers & Electrosurgery in General Surgical Practice.** Contact Carol Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.
29 - *St. Louis*: **Ethical Decision Making in the 1990's: Assessing Life Sustaining Interventions.** 5 credit hours. Contact Mary, St. Louis University School of Medicine Elizabeth Hogan, 577-8195.
31 - *St. Louis*: **Pediatric Immunology & Rheumatology for the Practitioner.** 6.75 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

November

2 to 4 - *St. Louis*: **Pediatric Advanced Cardiac & Trauma Support & Pediatric Advanced Life Support Provider Course.** 20 credit hours. Contact Mary Beth Foerstel, R.N., St. University Medical Center, 314/577-5385.
5 to 7 - *Kansas City*: **70th Annual Fall Clinical Conference.** Contact Linda F. Smutz, Kansas City Southwest Clinical Society, 7920 Ward Parkway, Ste. 206, Kansas City, MO 64114, 816/523-3383.
5 to 8 - *St. Louis*: **The International Society for Applied Cardiovascular Biology & Washington University School of Medicine, 3rd Bennial Meeting Toward Application of Advances in Basic Cardiovascular Biology.** Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.
6 - *Columbia*: **OB/GYN Update 1992.** Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.
6 & 7 - *Detroit, MI*: **40th Annual Detroit Trauma Symposium.** Contact Marjorie Norum, Dept. of Surgery, Harper Hospital 3990 John R., Detroit, MI 48201, 313/745-8778.
6 to 8 - *St. Louis*: **Practical Anatomy & Surgical Technique Workshop: Surgical Approaches to the Skull Base.** 28 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.
6 to 8 - *Rockville, MD*: **Fourth Annual Infectious Disease Review.** For more information contact, Svetlana Lisanti, Conference Coordinator, Center for Bio-Medical Communications, Inc., 80 West Madison Ave., Dumont, NJ 07628, 201/385-8080 or 800/231-0389.
9 - *St. Louis*: **Transjugular Intrahepatic Porto-systemic Shunts (TIPS).** City-Wide Radiology Conference by Ernest J. Ring, M.D. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.
9 to 13 - *St. Louis*: **Practical Anatomy & Surgical Technique Workshop: The 2nd Ugo Fisch Microsurgery of the Cranial Base Workshop.** 40 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.
10 to 12 - *St. Louis*: **Doppler Echocardiography: The Quantitative Approach.** 20 credit hours. Contact Dianne Reid, St. Louis University Medical Center, 314/577-8897.
12 & 13 - *St. Louis*: **Internal Medicine Update.** 10 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

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Continued on page 700

Continued from page 699

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Dennis Weiser, Managing Editor, *Missouri Medicine*, P.O. Box 1028, Jefferson City, MO 65102, 314/636-5151 (fax) 636-8552

INFORMATION FOR CONTRIBUTORS

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Manuscripts should be submitted to the editor, **J. Regan Thomas, M.D.,** P.O. Box 1028, 113 Madison, Jefferson City, MO 65102. The transmittal letter should designate one author as correspondent and include his or her address and telephone number.

In addition, in view of The Copyright Revision Act of 1976, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: **"In consideration of the Missouri State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA."** We regret that transmittal letters not containing the foregoing language signed by all authors of the submission will necessitate delay in review of the manuscript. Please include the title of the article in the transmittal letter.

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Manuscripts should be typewritten, double-spaced, and the original with one copy submitted. Retain another copy for proofreading. Please number the pages of your manuscript. Manuscripts are not returned. Hospital and University appointments of the author(s) should accompany the manuscript. A synopsis-abstract of no more than 75 words should accompany the manuscript. Manuscripts may be submitted on 5 or 3 floppy disks using WordPerfect 5.1 or below.

References

References should be cited in numerical order in the text and arranged at the end of the article in the same order in which they are cited. The reference should give name of author, title of article, name of periodical, volume number, initial page number and year. Authors are responsible for reference accuracy.

Illustrations

Illustrations should be glossy prints or drawings in India ink on white paper. They should not be mounted and name of author and figure number should be penciled lightly on the back. Legends should appear on a separate sheet.

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Editorials should be written in clear, concise language. Length should be about two or three pages typed with double spacing. Letters will be published at the discretion of the editor, managing editor, and Editorial Board.

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All material other than scientific should be received prior to the first of the month preceding month of publication.

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CompHealth Locum Tenens	655
Eli Lilly & Co.	691
HealthCare Administrative Services	684
Healthline Management Inc.	658
Jackson & Coker	690
Medical Defense Associates	652
Medical Protective Company	678
MOMEDICO	646 & 662
MonetaMed	648
MSMA Foundation	680
Omaha Clinical Society	655
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Physicians' Health Committee	680
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RCA Mutual Insurance	692
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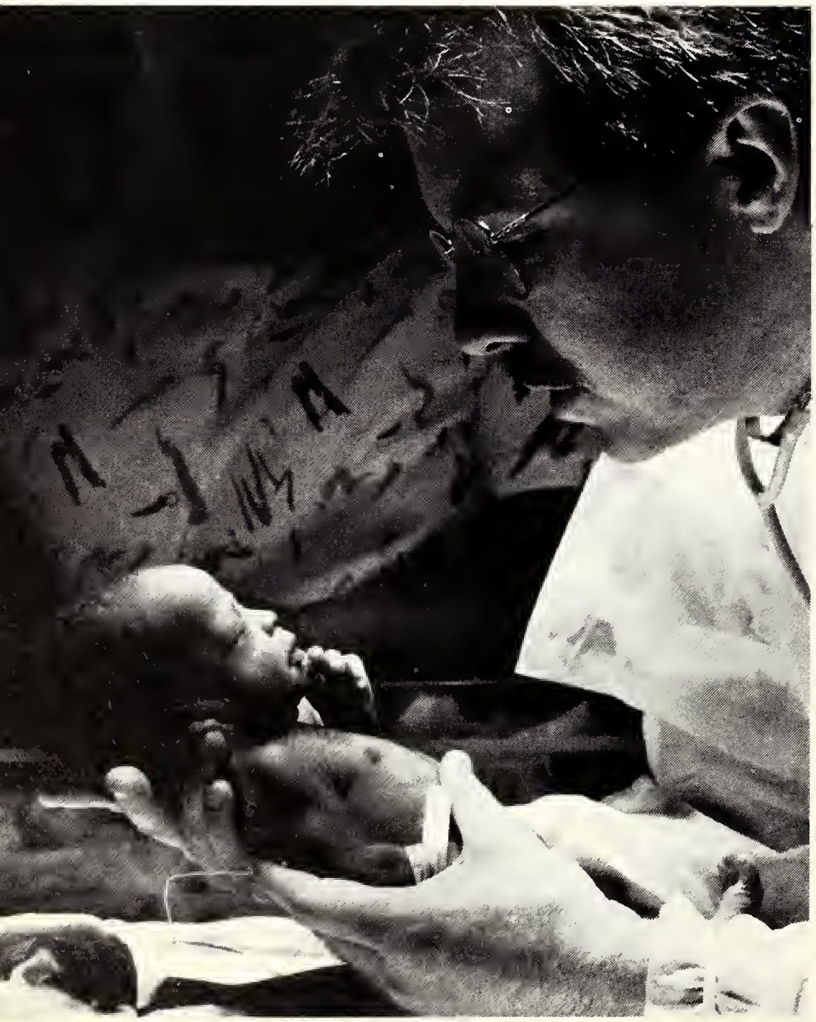

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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

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References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:13I-15I. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Missouri Medicine

Journal of the Missouri State Medical Association
October 1992

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Owned and edited since 1904 by the Missouri State Medical Association. *Missouri Medicine*, Journal of the Missouri State Medical Association, is published monthly at 113 Madison, Jefferson City, Missouri 65102. Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices. Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept. P.O. Box 1028, Jefferson City, MO 65102.

The subscription price per year for nonmembers is $20.00. Annual subscription for members is included in the annual membership dues. The international subscription price is $40.00. Single copies are $4.00 and the cost of copies of the annual August Directory issue is $15.00.

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Printed by the Ovid Bell Press, Inc., Fulton, Missouri 65251.

CONTENTS

VOLUME 89, NUMBER 10

THE FRANCIS A. COUNTWAY
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OCT 13 1992

Department of Health Statement

The Enigma of Lyme Disease in Missouri
H. Denny Donnell, Jr., MD, MPH **714**

Perspectives

NPDB: The Toy of the Imperial Congress
WHEN BAD THINGS HAPPEN TO GOOD DOCTORS
Arthur H. Gale, MD **720**

Personal Computing: Just Do It!
John C. Hagan, III, MD **727**

The Importance of Feelings
John Stuart Munro, MD **729**

Editor's Desk

This . . Not This!
Wilfred E. Wooldridge, MD, Contributing Editor **711**

Scientific Articles

Selected Topics in Breast Conservation Therapy
Karen J. Halverson, MD, Delia M. Garcia, MD, Marie E. Taylor, MD, and Carlos A. Perez, MD **731**

Bilirubin Encephalopathy in a Term Infant After Planned Home Delivery
Lisa L. Schroeder, MD and Timothy A. O'Connor, MD **741**

Departments

MSMA Officers, Councilors and Delegates **709**
Letters to the Editor **713**
President's Page **717**
Auxiliary Message **719**
Physician Recognition Awards **743**
Practice Management **745**
Residents' News **747**
New Members **749**
In Memoriam **753**
Medical School and Member News **754**
CME Calendar **757**
Classified Advertisements **759**
Information for Contributors **761**

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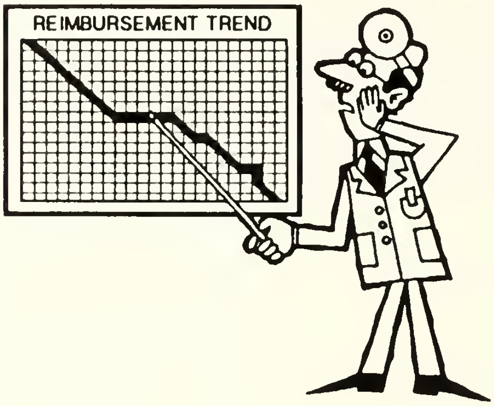

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Vol. 89, No. 10 October 1992

October Cover

"Leaving Impressions" is a watercolor by Medge D. Owen-Kummer, MD. She is a fourth-year resident in anesthesiology at the University of Missouri / St. Luke's Hospital in Kansas City. Her formal art education began while she was in medical school and, after she completes her residency, she hopes to pursue painting on a semi-professional basis. Her work is on exhibit this month in New Orleans at the American Society of Anesthesiologists' annual meeting.

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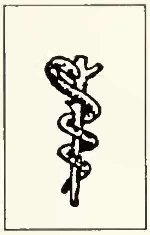
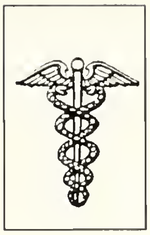
This  Not This! 

by Wilfred E. Wooldridge, MD, Contributing Editor

About every ten years I develop a fresh cramp because my medical profession stubbornly refuses to acknowledge its proper symbol. Hospitals know this symbol, podiatrists know it, osteopaths know it. Only the most feeble chiropractors, newspapers, television media and MY colleagues do not know it, and refuse to learn.

For a long time I, like most of you, considered the winged staff with TWO entwined serpents to be the correct symbol of medicine. We were dead wrong, notwithstanding the thousands of us who cluttered the world during WWII with those insignias on caps, collars and lapels.

This matter has a curious history. In 1818 the Medical Department of the United States Army quite properly adopted the insignia of the forked staff with a SINGLE entwined serpent. So did the American Medical Association in 1910. Then, for some incomprehensible reason, the U.S. Army Medical Corps later opted for the winged staff with two serpents. All the while, Britain, France, Mexico, all the South American countries, and every other nation I know, smugly regards our insignia as amusing. Considering the screwed-up track record of our armed forces, it really is amusing.

Now what is this all about? Let's get back to basics.

All of you will agree that Asclepius (Greek), or Aesculapius (Roman) is the God of Healing. With either god an accompanying snake was thought associated with healing, wisdom, longevity and immortality. The snake wound about the staff symbolized the ability to change from a lethargic state to one of activity and thus signified the life-giving power of the physician.

The winged staff with two entwined snakes is entirely another matter. This is the staff of Hermes (Greek), or Mercury (Roman), and is known as the caduceus. Neither Hermes, Mercury or the caduceus in any way represent the healing art. In fact, Hermes conducted the souls of the dead to hell. That, alone, should make the caduceus a discouraging symbol for medicine.

Further, mythology has it that Hermes one day found two snakes copulating. With his staff he separated them, thus thwarting nature and, lo, this pornographic symbol was born.

I suppose I attach too much to this, except for the sake of being correct. However, if my colleagues wish to be represented by two procreating snakes interfered with by Hermes, all well and good! I don't!

With current problems quite enough to be as much as medicine can bear, do we need this false, misleading and embarrassing label as well?

At least, this one is easy to correct. ❐

Editor's Note: Dr. Wooldridge is a former editor of *Missouri Medicine*, an Emeritus Clinical Professor of Medicine (Dermatology), University of Missouri - Columbia and a member of MSMA. He lives in Springfield, Missouri.

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State(s) where currently licensed

States where formerly licensed (for past 10 years)

Amount of Professional Liability Insurance now carried
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02

The following editorial was submitted to *Missouri Medicine* by Dr. Ed Masters, Cape Girardeau and is reprinted with permission from *The Southern Illinoisan*, Carbondale, Illinois, Vol. 100, No. 188.

Editor, Southern Illinoisan:

The opinion piece on Lyme disease published in *The Southern Illinoisan* on July 6 ("CDC should admit possibility of Lyme") does not accurately reflect the position of the Centers for Disease Control (CDC). CDC does consider the possibility that persons who experience the signs and symptoms of Lyme disease in southern Illinois have Lyme disease. The Illinois State Health Department reports these cases to us as Lyme disease from throughout the state when they meet the national surveillance case definition.

This case definition includes persons with a large, red, expanding rash at the site of a supposed or known tick bite (the so-called erythema migrans rash), and persons who have certain specific types of arthritis, neurologic illness or heart disease and a positive test for Lyme disease.

CDC also takes seriously the possibility that persons with signs and symptoms of Lyme disease acquire their illness from exposure to ticks (including the Lone Star tick) in Illinois and surrounding south central states. We have been conducting field and laboratory research on this possibility for some time. The first step in determining whether the Lone Star tick, or other ticks, may be responsible for transmitting this bacterium to people in a geographic area is to collect these ticks in the field and then find the bacterium in cultures made from these ticks. Scientists have not, to our knowledge, found the Lyme disease bacterium in ticks collected in southern Illinois.

The CDC has a special program of research and service on Lyme disease, which gives highest priority to surveillance, improved diagnosis, prevention and control. In addition to the research we do in our laboratories and in the field, CDC awards approximately $3 million annually to universities, state and local health departments and to private, non-profit foundations to conduct research on Lyme disease.

For more information on Lyme disease and measures to prevent this and other tick-borne diseases, health care providers and the public may contact the Illinois Department of Health at (217) 782-2016, the Missouri Department of Health at (314) 751-6400, the National Arthritis Foundation at (404) 872-7100 and the Centers for Disease Control at (404) 332-4555. Persons who suspect that they may have Lyme disease should request evaluation by their health care providers.

David T. Dennis
Chief, Bacterial Zoonoses Branch

Dear Editor:

Thank you for giving us the opportunity to comment on two letters received in response to our June article, "Research on Ticks and Tick-borne Pathogens in Missouri - An Interim Research Report."

The paper in question was what the title implied-- an interim report on ongoing research. We reported our results only and no other studies were cited. We are fully aware that our data at this point differ from those of some other individuals. It was clear in our article that this was a study still in progress.

Our microbiological methods are consonant with current knowledge. In particular, our procedure for dilution of polyclonal antibody preparations was deliberate and conservative. It should be pointed out that PCR homologies in the 97-98% range are not compelling evidence of conspecificity.

Nowhere in our interim report are discrete collecting sites identified. CDC tick collections in southeastern Missouri have given rise to conflicting interpretation. The ticks Dr. Masters mentions in paragraph 2 (and from which he indicates that *Borrelia burgdorferi* was isolated by CDC) are the same as those yielding the "much publicized CDC 'Missouri spirochete isolate'" that he says in his final paragraph "is not a true spirochete." The fact is that data currently available from the CDC study in Missouri are inconclusive. Our interim conclusions were based on our own data.

Dr. D. Feir voiced concern because we did not cite the conference report in which she and colleagues reported identification of the Lyme disease spirochete from Lone Star and American dog ticks. As stated earlier, we did not include a literature review in our interim report; further, we excluded mention of this nonprimary article deliberately and for a variety of scientifically valid reasons. We did not "conclude" (as Dr. Feir states) that the Missouri situation involves a pathogen other than *B. burgdorferi*; we simply posed this, along with vectors other than *Ixodes* species, as possibilities. Such conjecture is not original with us.

From a broad perspective, epidemiology can be viewed as the "applied ecology" of a disease. Our statement that "there appear to be significant dissimilarities between the epidemiology of Lyme disease as described from the northeastern U.S. and the syndrome currently affecting Missourians" is defendable. We use the term "Lyme-like" because of current uncertainty with respect to identification of the pathogen involved. Whether or not Lyme disease is a "clinical diagnosis" is beyond the scope of our project.

Sincerely,
Robert D. Hall
K. Arunika Hewadikaram
Gregory A. McDonald
Kathy E. Doisy

DEPARTMENT OF HEALTH STATEMENT

The Enigma Of Lyme Disease In Missouri

H. Denny Donnell, Jr., M.D., M.P.H.
Missouri Department of Health

Lyme disease was made a reportable disease in Missouri in 1989.[1] Patients with erythema migrans and patients with late manifestations which met the surveillance criteria jointly established by the Centers for Disease Control (CDC) and the Council of State and Territorial Epidemiologists[2] led the Missouri Department of Health to make this requirement. There were 108 cases reported in 1989 which met the surveillance criteria, 205 in 1990 and 207 in 1991. The most probable location of tick exposure was in 58 counties of the state for cases reported during these three years. There were 13 earlier cases which were reviewed in 1989 and found to meet the case criteria. The criteria changed somewhat for 1990 but essentially require evidence of erythema migrans or one or more of specified late manifestations along with laboratory confirmation of the infection. These criteria were established before the study of the laboratory tests by the State and Territorial Laboratory Directors documented the limitations of laboratory testing for Lyme disease.[3]

The dilemma in Missouri relates to the fact that, in what are generally understood to be "known endemic areas," the Lyme spirochete is vectored by *Ixodes dammini*[4] which has not been found in Missouri. The spirochete has also been found in *Ixodes scapularis* and *Amblyomma americanum* in "endemic areas" but it has been assumed that these ticks are either ineffective or less effective vectors. Culture remains the gold standard. There are molecular differences in the spirochetes from different areas of the nation and the world which are so great that some have suggested that they represent different species.[5] There is diversity in the antigenic strains of Borrelia even in the northeastern area of the US.[6] Immunologic tests for the presence of the spirochete or antibodies related to it are still in a developmental state and are notoriously difficult to interpret. The manifestations of the clinical disease are so numerous and diverse that CDC has stated that in the absence of highly specific laboratory tests Lyme disease diagnosis "relies predominantly on clinical features."[7] Although the disease can be debilitating, it is rarely fatal. The infection has been known to survive for many years despite antibiotic therapy and a recent study suggests that cells, including dermal fibroblasts may serve as protective havens for the spirochetes.[8] The physician who believes the patient to be infected is virtually obligated to give antibiotic therapy early and to continue to treat vigorously if the patient continues to be symptomatic.[9]

EVIDENCE FOR *B. burgdorferi* IN MISSOURI

1. Over 500 cases meeting the CDC-CSTE surveillance definitions have been reported in Missouri since 1983. The most probable site of exposure to ticks for these patients has been in 59 counties widely scattered but most highly concentrated in the counties south of the Missouri river. Clinically these Missouri patients manifest a variety of findings associated with Lyme disease including erythema migrans, arthritis, neurologic and cardiologic manifestations. A wide variety of laboratory tests including enzyme-linked immunosorbent assay (ELISA), Immunofluorescent assay (IFA), Western blot test (WBT), polymerase chain reaction (PCR), and urine tests are reported to be positive in Missouri patients. Skin biopsies submitted to several experts are reported to show spirochetes.

2. Entomologist Dorothy Feir with St. Louis University has found spirochetes in the midgut of ticks. These spirochetes reacted with the monoclonal antibodies against H5332 using IFA which is a standard test for *Borrelia burgdorferi* . She has passed these through a rabbit into other ticks. Her efforts to culture them were unsuccessful.[10] Li, Feir, Xie et al reported the use of PCR to confirm these Missouri organisms as *Borrelia burgdorferi* . Molecular homology analysis of a 371 base pair fragment showed 97 and 98% agreement with the molecular sequence of *Borrelia burgdorferi* . They found positive ticks in 7 counties including Bollinger, Cape Girardeau, Green, Jefferson, St. Louis, Scott and Stoddard. They reported that "no positive tests were observed with smears from 20 IFA-negative ticks from areas where no Lyme disease or IFA positive ticks have been detected."[11]

3. Midgut contents of *Amblyomma americanum* ticks have been examined by darkfield microscopy by CDC and organisms believed by the observers to be motile *Borrelia*-like spirochetes have been found.[12] (More ticks were collected in Missouri in July, 1992 and these will be examined with electron microscopy by CDC.)

4. *Ixodes dammini* is known to occur in the adjacent states of Iowa and Illinois.[13] It has been found in several counties in northern Illinois and in Monroe County, IL which is directly across the Mississippi River from Jefferson County, MO. The Illinois report describes the Monroe

County finding in guarded terms: "This was not a well-established population and ticks collected were not infected with *Borrelia burgdorferi.*" This was in contrast with the findings in northern Illinois where the ticks were found to carry the spirochete.[14] *Ixodes scapularis* is fairly widely distributed in Missouri. The differentiation of *Ixodes dammini* from *Ixodes scapularis* is based on very subtle anatomical differences. The two species have different host preferences but have been shown to interbreed in the laboratory.

5. The search for evidence for the Lyme spirochete in southern Illinois recently reported in a poster session at the V International Conference on Lyme Borreliosis found that one patient from Fayette County, IL (about 65 miles northeast of St. Louis) showed antibodies to the spirochete.[15]

6. A recent paper by Magnarelli found antibodies to *Borrelia burgdorferi* in cotton mice across wide areas of southeastern US including northeastern Mississippi about 200 miles south and east of Missouri's bootheel. Magnarelli also found that *Ixodes scapularis* and *Amblyomma americanum* harbored *Borrelia burgdorferi* in Alabama.[16]

7. Researchers in Oklahoma have found, with culture and passage, in mice and ticks an organism confirmed with monoclonal antibody H5332 as *Borrelia burgdorferi* . Isolations were made from white-footed mice and from *Ixodes scapularis* and *Dermacentor albopictus* ticks recovered from deer. Serologic studies using ELISA revealed infections with *Borrelia burgdorferi* in 4.5% of 240 dogs and 11.7% of 489 deer.[17]

EVIDENCE AGAINST *B. burgdorferi* IN MISSOURI:

1. Despite considerable effort it has not been possible to isolate the spirochete of Lyme disease from clinical specimens from Missouri patients. These efforts include submission of 45 skin biopsy specimens to the CDC laboratory since July, 1991 from various physicians.[18]

2. CDC failed to isolate the spirochete from a collection of over 3000 ticks gathered in July 1991 from sites where Missouri patients recalled tick exposure. Culture efforts by CDC initially revealed spirochete like objects which have recently been demonstrated to be artifacts known as pseudospirochetes. These are fibrils derived from flagella, aggregating in bundles and appearing as non motile spiral structures of variable size. CDC is continuing efforts to evaluate the possible role these materials might play in causing EM.[19]

3. Laboratory tests are not highly specific and are not well standardized. Analysis of paired sera from 39 erythema migrans patients in the July 1991 case control study found 44% positive with whole-cell sonicate antigen for *Borrelia burgdorferi* but only 5% positive with a more specific flagellar antigen test. None of the pairs showed a significant titer rise, but one showed a falling titer.[20]

4. The University of Missouri / Department of Health collaborative study has analyzed a large number of ticks without finding any *Ixodes dammini* or immunologic evidence for *Borrelia burgdorferi* .[21]

5. In 1988 over 1000 *Ixodes scapularis* ticks from Missouri white-tailed deer from 12 counties including southeast Missouri were examined in the laboratory of Dr. Willy Burgdorfer of the National Institutes of Health Rocky Mountain Laboratories without finding microscopic or serologic evidence for the spirochete bearing his name.[22]

DISCUSSION

Missouri patients are experiencing some of the early manifestations with skin lesions and some of the late manifestations which occur with Lyme disease. Efforts to prove by cultural methods that *Borrelia burgdorferi* exists in the state and is related to these illnesses have thus far been unproductive. There have been many positive serologic findings in patients, some observations of spirochetes in biopsies of lesions, many positive immunologic findings in ticks and some observations of spirochetes in the midgut of ticks. In the light of considerable immunologic and observational findings it has been very perplexing that the cultural methods which are so frequently successful in other parts of the country have not been productive in Missouri.

In a 1991 summary of the first decade of Lyme Borreliosis, Dr. Willy Burgdorfer mentioned the Missouri experience in the following words: "The state of Missouri...appears to be a new area where disease is endemic. There...the lone star tick, *A.americanum* is suspected to be responsible for maintaining and distributing *Borrelia burgdorferi* or *Borrelia burgdorferi* -like spirochetes."[23]

The Department of Health will continue to search for a causative agent which may turn out to be *Borrelia burgdorferi* or may turn out to be some other agent and we will continue to evaluate the patterns of occurrence of these conditions within the state. The Department of Health will continue to participate with the University of Missouri in collecting ticks for the study in which interim

Continued on page 716

Continued from page 715

results were reported by Dr. Robert Hall et al in the June, 1992 issue of *Missouri Medicine.* Patients who manifest symptoms of Lyme disease should continue to be reported to the local health departments while the search continues for the etiologic agent.

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Plugging the Gaps in Health Care

Carol Williams, M.D., MSMA President

During the spring and early summer of 1992, access to health care and reform of the health care system were topics for hot debate in the political arena. But, as the polls rolled in with figures showing that the public is not interested in paying for any of the reforms proposed, health care as a political issue has lost some of its earlier steam. It is a mistake, however, to assume that this lack of interest means nothing is happening to improve access to health care for those who are unable to pay for it.

Around the state physicians, hospitals, health departments, and concerned citizens are coming together and setting up facilities for improving medical care for the medically indigent patient. In some areas physicians quietly continue giving care to anyone who comes through the door, even when they can pay nothing or only a nickel on the dollar.

In Cape Girardeau, pediatricians, family practitioners, two hospitals, and the health department are setting up an after-hours facility to care for pediatric patients with such things as otitis media, sprains, cuts, and upper respiratory illnesses; in the past indigent patients with such conditions have crowded the emergency rooms when illness reached crisis proportions. The after-hours facility will provide earlier care in an office setting - a less expensive alternative to the emergency room.

A similar type of activity is getting off the ground in the metropolitan St. Louis area through the efforts of the pediatric staffs and administrators of Cardinal Glennon Children's and St. Louis Children's Hospitals, the city and county health departments, and the community health centers.

Boone County has established a comprehensive primary care clinic, the Family Health Center, in an under-served area of north Columbia. The center, staffed by two family practitioners from the University of Missouri-Columbia and by two public health nurses, offers care for entire families. Again, the aim is to provide a less expensive alternative to the emergency room.

Despite diminishing margins of income and the increasing cost of complying with regulations of all sorts, both rural and urban physicians continue providing care to Medicaid, Medicare, and those uninsured people whose age or income makes them ineligible for either government program. Other efforts by physicians and concerned citizens around the state are helping to plug the gaps in the provision of health care.

Whether or not major health care reform comes about in the next four or five years depends on the outcome of the next election and on the will of the electorate to take on an added tax burden. While reform may come at the national level, there is also the possibility that health care reform may come at the state level, as has happened in Oregon and Vermont.

MSMA introduced legislation patterned after the AMA's Health Access America in the last session of the Missouri Legislature; it was not passed as a whole but several provisions were added to other legislation which did get enacted. MSMA continues to work on legislation which will improve Missourians' access to care.

While we are waiting on legislative change, however, physicians and other concerned citizens have developed programs that assist uninsured patients to get medical care and insure more appropriate use of limited medical facilities.

These individuals' efforts are to be applauded; we owe them our heartfelt thanks and support. ❐

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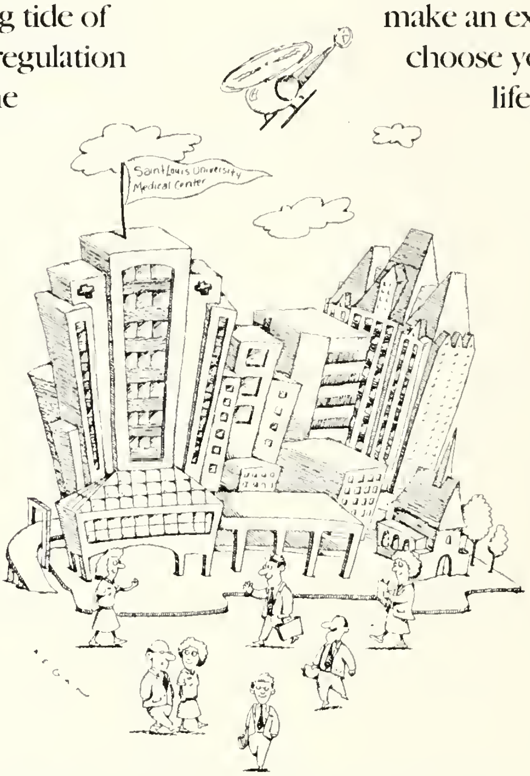
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Doctor, Can you spare some time?

Beverly Murrell, MSMAA Legislative Vice President

The crisis in health care accessibility encompasses all Americans, and new possible ways to reform the health care system appear each day to darken the cloud of confusion already engendered by myriad health-related legislative issues. You, doctor, cannot hide from these issues; some of them, at least, will affect you. But you can in turn affect their outcome by doing these things in this election year:

TAKE THE TIME TO UNDERSTAND THE ISSUES OUT THERE.

What are the differences between the three most likely packages of comprehensive health care reform at the national level: a single-payer system (like the Canadian), employer-based reforms and private market-based reforms? On the state level, what new bill will emerge from brainstorming of the Missouri Health Care Forum in which MSMA participates; and will it win out over the Universal Health Care bill? Will the Lay Midwifery Bill (opposed by MSMA) make it through both legislative chambers the next time? Will the State Legal Expense Fund Bill, vetoed by the governor, go through under a new governor? So many issues - hundreds! So little time!

Good sources of information include the *AMA News*, *Medical Economics*, *JAMA* and *Missouri Medicine* as well as the usual news magazines and newspapers. The League of Women Voters is studying health care in depth and has much information available. The MSMA office will send weekly legislative reports to those who sign up as Key Contacts.

TAKE THE TIME TO MEET YOUR CANDIDATES AND TO EXCHANGE VIEWS ON HEALTH ISSUES WITH THEM.

Support those candidates who are Medicine-friendly. After the election, continue to take the time to communicate on a continuing basis with the victorious candidates, in person or by letter or telephone. Invite your legislator to lunch; invite him/her to spend a mini-internship with you and another doctor. Be creative! It becomes easier with practice.

REGISTER TO VOTE, AND THEN DO IT ON TUESDAY, NOVEMBER 3rd

This would seem to be an unnecessary reminder, but an astonishing number of physicians and spouses are not registered. According to the AMAA, there are 420,000 active physicians and spouses - or about one million potential voters - in the United States; but only 51% are registered to vote. You, doctor enmeshed in the health care industry, must MAKE the time to accomplish this basic privilege. And remember to remind your new colleagues as well as the members of your family.

They have such refined and delicate palates
That they can discover no one worthy of their ballots,

And then when someone terrible gets elected
They say, There, that's just what I expected!

(From *Election Day is a Holiday*, by Ogden Nash)

Mark off the time now for Missouri State Medical Association Auxiliary's annual Day at the Legislature on Tuesday, March 2, 1993. Join your spouse for coffee 'n conversation with the legislators early in the morning (8:30 - 10:00 a.m.). Then visit the legislature in session, finishing with lunch and a tour of the governor's mansion.

NATIONAL PRACTITIONER DATA BANK: THE TOY OF THE IMPERIAL CONGRESS

WHEN BAD THINGS HAPPEN TO GOOD DOCTORS

by Arthur H. Gale, M.D.

The purpose of the National Practitioner Data Bank is to identify "bad doctors" and prevent them from moving to another city or state and setting up practice.

Like so many laws, it was proposed with good intentions but its harmful effects will far outweigh any benefits it may have.

The members of House of Delegates of the American Medical Association, the grass roots representatives of American doctors, recognized that the NPDB was a bad law. At the Interim AMA meeting in December of 1991, the House of Delegates voted to dismantle the National Practitioner Data Bank.[1] The Board of Trustees at the June 1992 AMA meeting recommended that AMA policy should call for modifying - not abolishing - the Data Bank. This is the current official policy of the AMA on the NPDB. The Data Bank was established under the 1986 Health Care Quality Improvement Act.

When the Data Bank was discussed on the floor of the House of Delegates of the AMA at the June 1991 Annual Meeting, a delegate stood up and stated that the problems with the Bank go beyond the "pocketbook concerns" that dominate the debate on other issues in the House of Delegates. "This deals with our basic rights as citizens, and these rights are being trampled. We must speak out against big brother."[2]

Indeed, the rights of doctors have been threatened. Since the bank has gotten under way, no one really knows how the information stored in the bank will be used, and no one knows whether the information can destroy a conscientious, capable physician's reputation and professional career. The National Practitioner Data Bank is bad law and, therefore, it is important to understand why and how it was established.

HISTORICAL BACKGROUND

The NPDB had its origin in the development of the peer review process. In 1970, the House of Delegates of the AMA adopted reports of the Council of Medical Services endorsing peer review and "urged all components of organized medicine to give energetic support to furthering peer review."[3] At the same time, a resolution was referred to the Board of Directors which sought protection against liability for peer review activities.[4] This resolution on granting peer reviewer immunity from litigation would ultimately come back to haunt organized medicine because it had laid the groundwork for the establishment of the NPDB.

In general, the delegates to the AMA supported the concept of peer review based on the simplistic notion that there were a few "bad doctors" out there and through the good offices of peer review, these "bad apples" could be eliminated. Over the years, however, there has been a gradual and profound change in the way physicians view peer review. Doctors began to figure out that the "bad doctor" was not the bumbling, substance abusing, incompetent caricature of physicians who shamed the medical profession. It was becoming apparent that peer review organizations had become or could become a monster, catching in their nets not just "bad apples", but doctors who are industrious, conscientious, and competent. A doctor who is accused, cited, or sanctioned by a peer review organization (PRO) might be an esteemed colleague or possibly even oneself.

The broad support for PROs which the AMA Delegates had shown in the past weakened. By 1986, resolutions on due process, and resolutions curtailing the power of the Inspector General of the Health Care Financing Administration (HCFA), and the PROs themselves were beginning to appear in the proceed-

Editor's Note: *Missouri Medicine* sent copies of this article and made several telephone calls to Representative Waxman and Wyden's offices to encourage their participation in this debate. Spokespersons for the representatives declined to comment on the data bank issue in general or Dr. Gale's article in particular. And, a statement from the AMA regarding the Board of Trustees' current recommendation to defer the implementation of Resolution 828 may be found on page 726.

ings of the House of Delegates.[5]

Physicians who had been well-trained in the sciences knew little about such areas of the law as basic rights and due process, but they were learning fast; unfortunately, the hard way. A resolution was actually introduced in the House of Delegates of the AMA in 1987 which called for the repeal of the peer review law.[6]

Public Law 99-660, the Public Health Care Quality Improvement Act of 1986 was sponsored by Representative Ron Wyden, Democrat of Oregon.[7] This bill had the support of three other members of the enormously powerful House Energy Committee, Representatives Henry Waxman, Democrat of California, Edward R. Madigan, Republican of Illinois, and Tom Tauke, Republican of Iowa. Wyden and Waxman were the chief supporters. The AMA, which had supported immunity for peer reviewers, initially strongly opposed the creation of the National Practitioner Data Bank and lobbied and testified against it at meetings with elected officials. The AMA actually favored establishing a clearinghouse within the private sector and had initiated some steps towards creating such an organization by expanding the use of its own physician master file. The AMA proposal for an expanded physician master file together with a clearinghouse for the Association of State Boards of Registration would be adequate for removal of "bad doctors."[8]

> ***"The increasing occurrence of medical malpractice, and the need to improve the quality of medical care can become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state."***
>
> ***Public Health Care Improvement Act***

But Representative Waxman and Members of the House Energy Committee insisted that physicians who did peer review would not receive immunity unless the NPDB was enacted. Why immunity for peer reviewers is connected to the NPDB remains to be explained. The Act was then ultimately supported by the AMA after arm twisting and hard bargaining with Congress. The AMA supported this Bill because it wanted immunity for peer reviewers and supported other measures contained within the Bill.[9] A quid pro-quo was established. Congress would grant immunity to peer reviewers if medicine would accept the NPDB. Now physicians who did peer review would not have to spend money to hire lawyers, or at times, even pay damages if sued by an angry reviewed physician. Unfortunately, once this bargain was struck, physicians lost something possibly worth more than even money; they had lost their "rights".

KINDS OF ACTIONS AND FREQUENCY OF REPORTS TO THE DATA BANK

The Health Care Quality Improvement Act of 1986, Title 4, Public Law 99-660, requires that four types of actions be reported to it:[10]

1. **Medical malpractice payments.** Each person or entity including the insurance company which makes a payment on behalf of any licensed physician as a result of a written claim or judgement must report that information to the Data Bank and the State Board of Medical Examiners.
2. **Licensure action taken by boards.** Each board of medical examiners must report to the Data Bank any disciplinary action based on reasons relating to a physician's professional competence or professional conduct.
3. **Clinical privileges.** Hospitals and other health care entities must report to their State Board of Medical Examiners when certain adverse actions are taken against a physician's clinical privileges.
4. **Membership actions.** Professional societies of physicians which engage in professional review activity through a formal peer review process for the purpose of furthering quality health care must report adverse membership actions to the Data Bank.

The major entries into the Data Bank will pertain to medical malpractice. From 9/1/90 to 11/8/91 there were a total of 22,162 reports to the National Practitioner Data Bank. Of these, 84.9% were medical malpractice payments, and 15.1% were adverse actions. About 2/3 of the adverse actions had to do with state licensing board disciplinary action. About 1/3 pertained to clinical privileges, and an almost negligible fraction pertained to professional society membership.[11]

Representative Waxman attempted to explain the Health Care Quality Improvement Act to physicians in an article appearing in the *New England Journal of Medicine* in 1987. He titled the article "Medical Malpractice and the Quality of Care."[12] He did not give equal billing to the other three actions which are contained in the law.

Waxman, Wyden, and other members of the House Energy Committee are obsessed with medical malpractice. Wyden and Waxman do not understand that a doctor who has had a malpractice settlement or a judgment is not necessarily a bad doctor. A physician who sees between 100,000 to 200,000 patients in a lifetime is going to sometimes make a judgement which in hindsight may prove incorrect. Or he may have a bad outcome or complication in one of his patients. Or, he may have lost a malpractice suit and not have deviated from professional standards of care. A recent study by the American Society of Anesthesiologists found that in 40% of the cases where an award or judgment was made, there was no deviation from accepted medical practice.[13] None of these actions by physicians would make him a "bad doctor."

The legislation containing the NPDB begins:

"The increasing occurrence of medical malpractice, and the need to improve the quality of medical care can become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state."

But when Wyden and Waxman talk about the increasing occurrence of malpractice, they are reporting an increase in litigation of all kinds. In 1960, there were 89,112 filings in Federal District Court. In 1990, the figure ballooned to 250,113, almost three times the 1960 level. From 1977 to 1989, the auto industry grew 40%, the food industry grew 90.9%,[14] and the legal industry grew 382%. With these statistics in mind, is there any reason why Congress should be surprised at the increase in the occurrence of malpractice suits. It is not medical malpractice that is increasing. Physicians today are far more skilled than their predecessors of ten, twenty, and thirty years ago. What is increasing is suits of all kinds and against all professionals, not only medical professionals, but against lawyers, engineers, accountants, etc.

WHY THE NATIONAL PRACTITIONER DATA BANK IS BAD LAW

The National Practitioner Data Bank constitutes bad law for four reasons:

1. ***It is bad because the basic premise underlying its creation is false,*** namely the bad doctor myth - that there are lots of "bad doctors" practicing medicine who need to be weeded out.
2. ***The law is bad because it is discriminatory.*** It singles out the medical profession. There is no National Practitioner Data Bank for other professions.
3. ***It is a bad law because it represents an abuse of power.*** The members of the House Energy Committee especially the four sponsors Wyden, Waxman, Madigan and Tauke railroaded this bill through the committee despite testimony showing that it was not needed and could be harmful. They then gained support for its passage in Congress. This is the story of how four powerful men, without good cause, created a nightmare for over 600,000 doctors with their computerized electronic toy.
4. ***It harms innocent persons.*** Many capable, conscientious, good physicians will find their names listed in the NPDB. A good deal of mischief can and will result from this listing.

Let us examine the first objection to the law, namely that it is based on the false premise of the bad doctor myth.

The myth of the "bad doctor" underlies the establishment of the NPDB. The major myth, according to Spencer and Halley, two surgeons (one of whom is an attorney) who wrote an impressive paper entitled "The Harmful Effects of the Bad Doctor Myth" is the assumption that competent, conscientious practitioners who become involved in malpractice claims and settlements are "bad doctors."[15] This assumption by unsophisticated congressmen, members of government, bureaucrats, legal organizations, especially trial lawyer groups, consumer groups, and the media is that bad doctors are the major cause of malpractice. This has led to the illogical conclusion that if one got rid of these bad doctors ("tort feasors") the malpractice problem would resolve. Ergo, the National Practitioner Data Bank. Spencer and Halley cite certain facts that support the contention that the major cause of the liability crisis is not "bad doctors:"

1. Increased frequency of litigation against neurosurgeons, orthopedists, and obstetricians have little or nothing to do with their competency. The United States has a reputation for producing the most highly-trained specialists in the Western World. Suits occur in this group because certain procedures have a higher probability of adverse outcomes in the absence of error.
2. Detailed studies of professional liability lawsuits have found no indication that increasing the physician's training or experience decreases the frequency of litigation. Conversely, despite advanced training and

board certification, the severity in monetary terms of lawsuits filed against physicians is often increased.

3. Studies characterizing professional liability have been conducted in several states. These studies found that each year there is a very small percentage of physicians who account for a high percentage of lawsuits. Frequently, these data are cited to indicate that "bad doctors" are the major problem. However, the composition of this small group changes from year to year. Physicians who are involved in lawsuits one year are not involved in other years. This is in keeping with actuarial predictions in all categories of insurance underwriting. In a recent study analyzing the Florida Medical Professional Liability Insurance Claims File, the authors concluded that "the empirical evidence of all studies, including their own, up to the present time, does not demonstrate that Claims experience is a valid indication of physician quality."[16]

4. Recent studies by medically-owned insurance companies showed that after evaluating many thousands of doctors, the number of physicians involved in liability suits who had surcharges added to their premiums or who had their policies terminated was only between 1.5-3.2% of all physicians.

5. In the American tort system, many non-meritorious suits are won. Malpractice is confused with complications. The recent Harvard Health Study,[17] the most extensive study to date of injuries in hospitalized patients, found that four out of five filed malpractice suits are non-meritorious. A major example of this phenomenon is in obstetrics where a diagnosis of cerebral palsy, which is almost never the result of pre-natal injury, can result in a huge judgement awarded by a jury against a capable and innocent doctor.

The incidence of malpractice suits being filed against a physician starting practice who cares for seriously ill patients is extremely high. More than three-quarters of obstetricians, one-half of all surgeons, and one-third of all doctors have been sued.[18] If 60-70% of malpractice suits are defended successfully,[19] then 25-30% of all obstetricians' and surgeons' names will end up in the National Practitioner Data Bank. 25-30% of obstetricians and surgeons are not bad doctors, any more than 25-30% of lawyers, accountants, or engineers are bad professionals.

The same "bad doctor" myth that applied to malpractice suits applies to peer review organization sanctions and licensure revocations. The number of physicians who are disciplined by state licensing agencies and the numbers of physicians sanctioned by PROs is very small. A recent report by the Federation of State Medical Boards revealed that the national average for disciplinary action was less than 1/2 of 1% of all physicians.[20]

The second reason that the Data Bank is bad law is that it is discriminatory. It is interesting to note that Congress has not passed stringent peer review laws for any other profession. For example, there are tens of thousands of lawyers, accountants, and engineers who work directly for the government or who contract privately with the government, or who use the government facilities like the courts at no cost. For these professionals, there has never been a comparable peer review organization or a National Practitioner Data Bank, nor will there ever likely be one. In other words, Congress has passed laws which apply to one group but not to others.

This double standard should not be surprising to anyone familiar with the actions of Congress. Congress has exempted itself from some of the most important laws of the land including the Social Security Act of 1933, the Civil Rights Act of 1964, the Freedom of Information Act of 1966, the Occupational and Safety and Health Act of 1970, (OSHA), the Equal Employment Opportunity Act of 1972 (EEOC), the Privacy Act of 1974, the Ethics in Government Act of 1978, and the Civil Rights Restoration Act of 1988.[21]

This topic was addressed by the principal author of our Constitution over 200 years ago, James Madison. He stated in the Federalist Papers:[22]

"The House of Representatives . . . can make no law which will not have its full operation on themselves and their friends, as well as the great mass of society. This [circumstance] has always been deemed one of the strongest bonds by which human policy can connect the rulers and the people together. It creates between them that communion of interest and sympathy of sentiments of which few governments have furnished examples; but without which every government degenerates into tyranny."

Tyranny was finally recognized this past December at the AMA Interim Meeting in Las Vegas where the AMA adopted a resolution calling for the dismantling of the NPDB.

The third reason that the law is bad is that it constitutes an abuse of power. Congressmen Wyden and Waxman never gave an adequate explanation of why an NPDB costing several hundred million dollars to establish and tens of millions of dollars each year to run was necessary. Wyden and Waxman never cited the scientific studies which enumerated the number of "bad doctors" which would require the establishment of such a complex and costly apparatus as the NPDB. With a self-assurance usually reserved for those who rule by divine right, they pushed the NPDB through their committee based on their own preconceived notions, not on the data presented to them by organized medicine.

In the previously cited article in the *New England Journal of Medicine* Waxman attempts to explain to the medical profession why it needs an NPDB.[23]

He cited three reasons for the passage of the Bill.

Two have to do with medical malpractice: First, the NPDB will somehow "moderate the incidence of medical malpractice"..."The limited data available will point to a tiny fraction of incompetent physicians responsible for a large share of paid malpractice claims." The fallacy of this contention has already been discussed. The small number of doctors who pay malpractice changes from year to year; and they are not incompetent, they are often the best and the brightest of physicians.

> **"Malpractice settlements, like all legal settlements, are made without admission of guilt or liability by the defendant. So why should this information be included in the Bank?"**

Waxman and Wyden were told that instead of the tiny number of incompetent physicians, a large number of competent physicians in the specialties most demanding and whose procedures are most risky, will be listed in the NPDB. Indeed Waxman states that his subcommittee heard about good doctors being sued but he simply ignored the testimony before his own committee.

Then Waxman goes on to state that the NPDB will help improve the lack of timely and accurate information on malpractice. This information has already been collected in a number of studies and was available to Waxman and his colleagues in the House Energy Committee. Waxman chose not to review it objectively and ignored its conclusions. It is difficult to understand how a dossier filled with the names of competent conscientious physicians will "improve" the lack of timely and accurate information on malpractice."

Waxman's third reason in explaining the need for a physician data bank is that the medical profession has to convince the "public" that it is doing everything reasonable to police itself. Waxman never defines who the public is which is clamoring for doctors to police itself. He does not cite public opinion polls on the competency of doctors; he does not cite letters from constituents; he does not ask organized medicine for polls or information concerning what patients think of their doctors. Could it be that the source of Waxman's "public" are some very powerful interest groups?

Is the "public" the strident and often inaccurate consumer organization *Public Citizen* led by Sidney Wolfe, M.D. with a membership of 1/20th of 1% of the American public? Most primary care physicians in the State of Missouri see more patients in one year than constitute the entire membership of *Public Citizen* in the State of Missouri.[24] These patients are quite aware of their physician's efforts on behalf of their health. I personally have never heard one person complain about the failure of the medical profession to police itself nor have other physicians.

Is the public the Trial Lawyer Associations who have a great financial interest in perpetuating the "bad doctor" myth and who specialize in weeding out bad doctors and bad manufacturers, but show little zeal for weeding out bad lawyers and bad judges? Or is the public the media talk shows best exemplified by *Donahue* or so-called investigative reporting shows such as *60 Minutes* and *20/20* which are basically entertainment and which can hardly be described as scholarly or objective?

Is the public the government bureaucrats whose jobs depend upon weeding out bad doctors. A report from the General Accounting Office (the GAO) in 1987 concluded that "the best way to deal with medical malpractice is to prevent its occurring."[25] This report was mainly a collection of opinions from different public groups. Most of the recommendations in this report focused on detecting bad doctors and as a result of this report there has been an increase in activity by the State Boards of Registration. Spencer and Halley conclude that the assumption that malpractice problems will be significantly improved as a result of these endeavors has never been proved and is almost certainly false.

Does the term "public" ultimately reflect the prejudices of very powerful Congressmen who happen to be members of the House Energy Committee who have been influenced by some very powerful interest groups?

The fourth and final reason for objecting to the law is that it is harmful to capable and conscientious doctors. It is not necessary to have an NPDB in which names of vast numbers of physicians who treat patients with complex illness will appear. For example, as mentioned previously, the Bank will contain the names of physicians in high-risk subspecialties where 50-75% of the physicians are sued.[26] The bank can be abused by physicians who sit on hospital credential committees, licensing boards, and quality assurance review committees. Physicians who are in competition with other physicians, physicians who hold a grudge, will use the information in the National Practitioner Data Bank to exclude other capable physicians, their competitors, from a hospital medical staff. Originally, the National Practitioner Data Bank was forced on physicians so that they could engage in peer review with immunity. As was pointed out, they would not be subject to anti-trust laws if they engaged in good faith review. Instead, the NPDB, in my opinion, will violate the spirit, if not the letter of anti-trust legislation. Many anti-competitive actions will be taken by physicians on credentials committees who will use the Bank for their own personal ends.

Also, erroneous information can be entered into the Data Bank and remain there forever, even if the physician contests it. Confidentiality of this information is supposedly protected, but it can and probably will be breached. Malpractice settlements like all legal settlements are made without admission of guilt or liability by the defendant. So why should this information be included in the Bank? This information should not be entered into the National Practitioner Data Bank as it is under present law. Raw data, not legal evidence which requires confrontation and cross examination of one's accuser, can be included in the Bank. This information can then be used to deny credentials of physicians on hospital medical staffs. These physicians may then lose the right to practice their profession.

Waxman, in explaining the need for developing a National Practitioner Data Bank gives an example of the type of physician who will be reported to the bank. He cites two anecdotal cases of incompetent physicians as reason for creation of the NPDB. One of the physicians was Donal Billig, M.D.[27] From the standpoint of trying to justify the need for the NPDB he could not have picked a worse example.

Donal Billig, M.D. the former chief of cardiac surgery at Bethesda Naval Hospital was convicted of involuntary manslaughter and negligent homicide by the United States Navy. He is the only physician in the history of the United States - military or civilian - to be convicted of negligent homicide during the course of patient treatment. Dr. Billig served 25 months of a four-year sentence in prison before he was released after successful appeal. The Appeals Court disagreed with Dr. Billig's conviction in almost every regard. The prosecutors were reported to have engaged in a "smear campaign" against him.[28]

It is ironic that the Billig case, according to Waxman, was one of the main reasons why the NPDB was created. Actually, Dr. Billig is a perfect example of a doctor victimized by the "bad doctor" myth and is a perfect example of why the Act should never have been introduced. Herein lies a tragedy. An innocent doctor is imprisoned for over 2 years. There will be many other innocent "victims" whose names will appear in the NPDB.

CONCLUSION

The problem of identifying "bad apples" could be easily accomplished by expanding the AMA master file to include the tiny number of physicians - 1/2 of 1% annually, who have had serious disciplinary actions taken against them by their State Board of Registration. This master file could also contain the 1.5 to 3.2% of physicians who have had multiple malpractice judgments and settlements and have had their insurance terminated or have had surcharges placed on their policies.

The creation of the NPDB is reminiscent of police state societies not the democratic society in which the rights of all citizens including doctors are protected. The revelations of the extensive spying that went on in eastern European countries such as in East Germany where dossiers were kept on all citizens, including innocent people, makes freedom loving Americans shudder. Yet the same sort of dossier is being introduced in the United States under the NPDB. History teaches us that when one individual's rights are trampled, the rights of all citizens are threatened.

If the NPDB resembles the policies and laws of police states then the authors of the NPDB, our elected representatives in Congress (who once elected are almost always re-elected) resemble the autocrats and dictators who run such police states.

The passage of this law constitutes just one more reason why physicians will be unwilling to treat difficult and risky cases. Fear of a malpractice suit and inclusion in the NPDB will also have a chilling effect on the introduction of new procedures. Access to care by the indigent, the elderly, and the rural populations will be jeopardized. Physicians will be unwilling to care for charity cases whom they have never seen before because of fear of a malpractice suit and inclusion in the Data Bank.

The government has interfered in every phase of medicine. Not only regarding fees, but telling the physician how to practice. The creation of the NPDB is one more reason why physicians view the United States government as arbitrary, oppressive, and tyrannical. The creation of the NPDB is one more example of the "weakening of the fragile bonds" which, as stated by Madison, "connect the rulers and people together."

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Report QQ of the AMA Board of Trustees on the National Practitioner Data Bank

At the 1991 interim meeting, the House of Delegates adopted amended Resolution 828 (Policy 355.991, AMA Policy Compendium 1992 Edition). The policy calls for the American Medical Association to seek to abolish the National Practitioner Data Bank (NPDB). The purpose of this report is to discuss the political and practical implications of this policy and to request deferral of action on this policy at this time.

Since enactment of the NPDB in 1986, the AMA has worked to remedy the many problems and shortcomings of the NPDB. These good-faith efforts were predicated on the view that the stated purpose of the NPDB, protecting the public from incompetent practitioners, should be furthered and the AMA has been successful in getting the government to address concerns with the NPDB. Changes have been made at the request of the AMA: 1) mailings from the NPDB have been modified to reflect their confidential nature; 2) the NPDB has backed off from their previous position to expand data elements relating to malpractice actions; and 3) there is no reporting requirement for impaired physicians referred for treatment. The sentiment behind the policy position to seek repeal of the NPDB is well-rooted, based on the existing problems with this program. However, the AMA's abilities to limit unwarranted expansion and to continue to address current deficiencies in the NPDB is jeopardized by the current explicit policy to abolish it.

Implementation of current policy as contained in Resolution 828 also presents clear risks to physicians. An explicit policy to abolish the NPDB has provided proponents of the NPDB with a handy scapegoat to blame for the problems of this program. Some charge that the current policy manifests a return to the so-called "conspiracy of silence." In addition, there are those who would turn the NPDB's poor performance into a rationale for expanding it -- requiring the reporting of all open malpractice claims or by mandating public access to the NPDB as some have advocated from the very beginning. It is also difficult to call for repeal at this time without compelling evidence of actual harm caused to innocent practitioners.

The Board therefore believes that it is in the best interests of physicians and their patients for the AMA to continue to work to remedy identified problems with the NPDB to achieve operational goals by pursuing the many concerns expressed by the House regarding the current operation of the NPDB.

The Board therefore RECOMMENDS

1) The following policy statement be adopted: The AMA shall continue to vigorously pursue remedial action to correct all operation problems with the NPDB.
2) That implementation of Resolution 828 (I-91) (Policy 355.991, AMA Policy Compendium, 1992 Edition) be deferred until it is determined that the above referred operational problems cannot be corrected at which time it would be appropriate to seek repeal; and
3) That the remainder of this report be filed.

PERSONAL COMPUTING: JUST DO IT!

By John C. Hagan, III, M.D.

Apple Macintosh, Super VGA, 85 MG hard drive, DOS, modem, RAM, software, mouse, fonts, floppy disk, AUTOEXEC.BAT, 256K cache memory, WINDOWS, cursor, post-script printer, CD-ROM.

If you know what even half of these words mean you can probably skip this article. On the other hand if not a single cerebral neuron fired off in recognition then you are probably computer illiterate. Excuse me! With due respect to political correctness-*technologically challenged*.

Over the last ten years I've worked my way up from a Smith-Corona manual typewriter to a IBM 486/50 MHz computer with enough power and accessories to dim the house lights when I turn it on. Small children from around the neighborhood knock at the door and ask if they can look at my computer, teenagers come by to run their favorite games on the high resolution monitor and my wife warns me I am dangerously close to becoming a computer geek.

I would like to espouse the joys and benefits of personal computing. I am assuming that every progressive physician has computerized their medical office. If you haven't, I suggest you forgo this article and find one on the necessity of the contemporary medical office being computerized. First things first.

You begin personal computing by asking what you would like to have the computer do for you. The most common computer applications are: word processing, database and spreadsheets, personal finance, desktop publishing, information retrieval and reference, recreation and gaming, communications, networking and custom graphics especially 35mm slides. In the process of personal computing you will acquire a basic computer literacy necessary for advanced business and professional practice.

Computing requires hardware and software. Hardware is the equipment and machines. Software is the computer programs that run the hardware. Hardware consists of the CPU or central processing unit and peripherals. Peripherals include a monitor, keyboard, mouse, printer, and a modem. The monitor is the screen that displays the computer's data. A "mouse" is a device for rapidly moving the computer cursor, executing commands and is highly recommended. A modem is a device for connecting the computer to the phone lines to communicate with other computers, networks or reference sources.

Apple and IBM (or IBM-compatible) are the two main choices of CPUs. Both are excellent systems and you cannot make a bad choice. My system is IBM, my two daughters have Apples. Computers, like automobiles, come in different grades of complexity and expense. Medium level cost and performance would be good choices even for beginners. In IBM this would be a 486 system and in Apple a McIntosh. A system should allow for growth and expansion and bare bones systems are too soon outgrown. The personal computer industry recently began a price war that has lowered prices by 30-40% on many models. Excellent, high performance systems can be had for $1,500 to $2,500. Sale price is usually negotiable.

A key word for computers is memory. Like closet space it is hard to have too much memory. The computer hard disk drive is its engine and should have at least 100 Mb (megabytes) of memory and 4 to 6 Mb of RAM (random access memory). The computer runs on disks or "floppies" that come in 5.25 and 3.5 inch sizes and the computer should accommodate both.

Striking high color resolution is now possible with the combination of a color monitor and a video card or board that is installed inside the computer. A monitor made by NEC and a Boca Research Super X VGA video card is an excellent combination. Hold off on the modem until you've mastered the basics and find a need for one. While in use it will tie up your phone line. The last piece of hardware is a printer. Relatively inexpensive dot matrix printers are available but if you plan on doing word processing or desktop publishing, then get one of the new personal laser printers. Those made by Hewlett Packard are well regarded.

Hardware and software can be purchased from full service computer stores, general retail stores or from large mail order firms. A full service store will help you choose the computer system tailored for your anticipated needs. They will put the system together, install the software and help you learn to use the programs. Several hours of free instruction should be part of the purchase price. After the sale service is an essential. The computer technician that doctors my system is like a member of the

Just Do It! Continued from page 727

family. He's always available for a phone consultation and he even makes house calls. Mail order firms are usually the least expensive but support services are often deficient. Moreover assembling a computer system and installing the software is a daunting task for a neophyte.

Software offers even more choices than hardware. Word processing is among the most popular applications. For physicians that publish and do research a word processing program is an absolute necessity. Good typing skills are essential for word processing and very helpful for all phases of personal computing. Word processing programs can check not only spelling but also syntax and grammar. Editing features include print previews that show the appearance and layout of the page before it is printed. Among the most popular programs for word processing are Microsoft WORD and WORDPERFECT.

An excellent software choice for all round use is MICROSOFT WORKS. It has a professional word processing program, data base, spread sheet and a communications program. Graphic programs allow the creation of custom made 35 mm slides and other artwork. Data can be entered and automatically graphically represented. Two respected programs are HARVARD GRAPHICS and APPLAUSE II. For running two or more software programs simultaneously Microsoft WINDOWS version 3.1 is the answer; for desktop publishing MICROSOFT PUBLISHER.

Once the computer system is assembled and the software installed you learn to use the programs by the instruction manuals and running the programs. Many of the software programs have interactive tutorials that will instruct you on how to run the program. Computer software programs also have a "HELP" function that explains how to execute a task. Many full service computer stores have user groups for formal instruction courses on essentials of computing. Most experienced computer users are willing to advise or discuss problems with hardware or software.

Commercial database services are available which for a price offer a plethora of valuable functions to personal computer users. Two of the most well known are COMPUSERVE and PRODIGY. These services offer 24 hours per day news, weather, sports, on line encyclopedia and reference sources, home shopping, electronic mail, travel information, and the ability to make plane, motel/hotel, and rental car reservations. They also have users groups that via electronic bulletin boards discuss all aspects of computing.

Computer literacy has become an absolute essential for the educated professional. Personal computing can and should be mastered by all physicians. As the NIKE commercial says - **JUST DO IT!** ❐

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PERSPECTIVES

THE IMPORTANCE OF FEELINGS

By John Stuart Munro, M.D.

Feelings experienced by physicians in their clinical work are not a nuisance to be ignored or suppressed but are important and should be recognized. Feelings provoked by a patient may be an important diagnostic clue. By recognizing his own feelings a physician can avoid acting inappropriately on these feelings. It is important for medical students to be encouraged to recognize and, where appropriate, express their feelings.

I was recently told of an experience encountered by a group of first-year students in our medical school. On a routine assignment to the emergency room of one of our teaching hospitals, they witnessed a tragedy. A child had died. The death of a child is always a tragedy, but in this case the child belonged to a co-worker of the emergency room personnel. The identification and empathy which the staff felt was more intense than the emotional impact associated with the death and suffering that they were used to managing on a daily basis. Some of these professionals were crying.

The person telling me of the situation appeared worried and wondered if this exposure of the young medical students to such a scene was likely to be in some way harmful to them. I said that I didn't think so. They may not yet have had to face the impact of death's capriciousness and disregard for feelings and sensibilities, but they could not be shielded forever. In fact, they learned a valuable lesson - that health professionals are not machines; they have feelings like other people and these feelings are important to recognize and, in appropriate circumstances, to express.

Feelings can be mistakenly viewed by some physicians as an obstacle to patient care, a nuisance to be ignored or suppressed. But feelings generated in a caregiver during an interaction with a patient are meaningful and worthy of our attention. One of my mentors during residency would initiate each post-interview discussion (after the patient had left the room) with the question, "What feelings did you have during the interview?" He would generally begin with the student interviewer but would frequently continue around the room as a pedagogical exercise. Typically we would begin with, "Well, I thought she met the criteria for..." The gentle interruption would be, "That's not what I asked. How did you feel?" The lesson was twofold. He would show us the clinical relevance of our feelings but he also taught us something about ourselves - that we physicians as a group are inclined to be thinkers rather than feelers - quick to analyze, slow to sense.

When patients make us feel sad, that is an important finding. Many depressed patients carry with them an aura of discouragement and demoralization that is infectious. Many depressed patients are also unable to attach the appropriate descriptors to their feelings so as to tell the physician in so many words that they are depressed. Reports of back pain, insomnia, and fatigue are sufficiently common and non-specific that many of us will not be alerted to look for this profoundly devastating condition. We now have good data to show that although depression's effect on social functioning (e.g. days in bed) is as great as that of hypertension, diabetes, and arthritis[1,2] it continues to be overlooked far too often by both psychiatrists and non-psychiatrists.[3] But if we can also be aware of our own sadness when it is provoked by an in cognito depressed patient, it can literally bring us to our senses.

Other patients will make us feel angry. There is no law or code of ethics which states that doctors shall not feel anger towards a patient. There are many which prohibit the acting out of such anger. But the best insurance against such an occurrence is the awareness of the anger by a physician who continually examines his or her feelings.

When feelings are ignored, they do not always disappear into oblivion. They may be redirected onto innocent bystanders, including our colleagues and families. Or they may die down to an imperceptible glow until rekindled by new fuel and burst with a hundred other rekindled feelings into a puzzling, out-of-place flame.

There are times when a caregiver's feelings of concern and compassion are difficult to distinguish from sexual longings and professional boundaries may be at risk. So real is the danger of this situation that most medical organizations have come forward in their codes of ethics to make a clear statement about the inappropriateness of a doctor-patient sexual relationship.

A friend shared with a me a painful memory

Feelings - Continued from page 729

surrounding the death of her son. He collapsed suddenly at the age of seven and was rushed to the hospital. Her memory is vivid for the moment when the attending physician walked into the waiting room to say, "Your son is dead...he had a very rare syndrome. I've only seen two other cases before. I would like to do an autopsy as part of my research..."

We could condemn this physician for his lack of empathy and inability to meet my friend's most significant need at the moment, the need for another human being to at least acknowledge, if not share, her pain. But we could also forgive him if we see his terror as the witness to such an exquisitely painful moment. He was protecting himself from his own riotous emotions.

We can all construct in our minds a preferable response by the physician. He would allow himself to be aware of his own pain and he would confront the pain of this anguished mother without fleeing. He would tolerate the experience of his own feelings and the nearness of another's. The silver lining to this story is that the physician did glimpse his retreating self, confronted it, and returned. He apologized and sat with her as she wept.

Another reason physicians might avoid confronting their feelings is that they may have been discouraged from doing so in their training. A colleague in my department has made the point that the primary obstacle to learning is the fear of humiliation. As educators, we have not always understood this concept. Sadly, humiliation has often been used as a teaching tool, which is transmitted from one generation to the next.[4]

One of our goals as medical educators ought to be to create a safe place to learn. We all need a safe place to explore new ideas, to examine hypotheses, and to be wrong. We need a safe place to think. But, just as importantly, we need a safe place to feel.

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SELECTED TOPICS IN BREAST CONSERVATION THERAPY

Karen J. Halverson, MD, Delia M. Garcia, MD, Marie E. Taylor, MD and Carlos A. Perez, MD

Breast conserving surgery followed by irradiation is now considered an acceptable alternative to mastectomy for patients with stage I and II breast cancer[1,2,3,4]. In fact, a recent NIH consensus conference concluded that, "breast conservation treatment is an appropriate method of primary therapy for the majority of women with stage I and II breast cancer and is preferable because it provides survival rates equivalent to those of total mastectomy and axillary dissection while preserving the breast"[5]. Over the past 15 years, the literature regarding breast conservation therapy (BCT) has grown exponentially. With increasing information, many issues have become the source of controversy regarding patient management. The importance of appropriate patient selection, as well as optimal surgery and radiotherapy, has become apparent[6,7,8,9].

The following is not intended to be thorough review of the literature regarding BCT. Rather it is a discussion of some of the more frequently encountered management problems. Topics to be covered include 1) the significance and appropriate management of patients with extensive intraductal component; 2) the significance of margin status and the appropriate management of patients with close or positive resection margins; 3) the interaction and sequencing of chemotherapy and radiation therapy following breast conserving surgery; 4) the role of breast conservation for women with large primary tumors; 5) the necessity of radiotherapy following conservative surgery in patients with very small primary tumors; and 6) treatment of breast recurrences following breast conservation therapy (BCT).

EXTENSIVE INTRADUCTAL COMPONENT

Extensive intraductal component (EIC), as defined by investigators at Harvard Medical School, is considered present when in an invasive breast cancer 25% or more of the tumor area is comprised of intraductal cancer (DCIS), and intraductal cancer clearly extends beyond the infiltrating margin[10]. In the Harvard University experience[11], the 5- and 10-year actuarial risk of breast recurrence was 23% and 33% when EIC was present, versus 5% and 8% in the patients in whom this feature was absent ($p < 0.001$). Most of these recurrences were near the site of the original primary tumor. To note, their series contained an unselected population, in which the "large majority" underwent gross excision with a "small rim" of adjacent breast tissue without regard to the margin of resection[12].

Have other investigators confirmed this association between DCIS within the tumor and an increased risk of breast recurrence? As shown in Table 1, studies have yielded inconsistent results[13,14,15,16,17,18,19]. The risk of breast recurrence when ductal carcinoma is present ranges from 4% to 30% versus 1% to 15% when it is not present. In our

Table 1

Incidence of breast failure by the presence of DCIS with the tumor

Study	Percent Breast Failure DCIS Extensive or Present	DCIS not Extensive or Absent
Zafarini (15)	11%	6%
Bartelink (16)	9%	1%
Kurtz (14)	18%	8%
Lindley (13)	30%	15%
Clarke (19)	4%	6%
Delouche (18)	10%	8%
van Limbergen (17)	10%	9%

experience with 511 patients with 519 Stage I and II breast cancer treated with breast conserving surgery and RT, when DCIS was present, the actuarial breast relapse at 5 years was 7% in patients with T1 primaries and 14% in those with T2 primaries. This compares to 4% (T1) and 7% (T2) when DCIS was absent. The source of this variation is most likely multifactorial. Not all authors have adhered to the definition of EIC as described by the Harvard investigators; many have included patients with a mere presence of ductal carcinoma in situ. Furthermore, these are retrospective reviews, with a great variation in the extent of surgery; depending upon surgeon preference, breast size, and institutional philosophy, surgical tumor resection has included quadrantectomy, wide excision, or biopsy. It should be noted, however, that in most there was only gross excision of tumor with no assessment of the microscopic margins.

Why would EIC increase the risk of breast relapse? Holland, et al. Examined 217 mastectomy specimens, and found that when EIC was not present, only a small percentage of patients had further ductal carcinoma in situ well beyond the edge of the primary tumor[19]. In contrast, in patients in whom EIC was present, approximately 40% had intraductal carcinoma at one centimeter, 30% at two centimeters, and 25% at three centimeters from the edge of the tumor. In their experience EIC correlated strongly with a prominent component of residual cancer in the remainder of the breast following a lumpectomy. Lash and coworkers found that residual DCIS outside of the primary cancer was more likely with an increasing proportion of DCIS within the tumor[20]. They did not, however, find a significant correlation between local relapse and DCIS following segmental mastectomy. Moreover, the presence of DCIS did not adversely impact survival or distant recurrence.

Several studies have shown that in general local control is influenced by the extent of resection, with fewer recurrences appearing after quadrantectomy or wide local excisions than after biopsy alone[8]. Even for patients not at high risk for local failure "adequate surgery" is needed to reduce the amount of residual cancer within the breast to a level that can be controlled with moderate doses of radiation. Thus, for patients with EIC, who are known to have a higher breast burden of cancer, wide local excision is of particular importance[22,23].

For patients with EIC on the initial excision, adequate surgical resection is mandatory; and options available include immediate mastectomy (which is preferred by many surgeons, however, deprives many women the chance to preserve their breast), or re-excision to ensure negative resection margins. Although mastectomy may be most prudent if positive margins are again encountered after re-excision, chemotherapy in addition to RT, may be considered. As will be discussed later, the addition of chemotherapy to radiotherapy in patients with EIC has been shown in one series to decrease the risk of breast recurrence.

MARGINS OF RESECTION

Between 10% to 20% of patients have positive margins after the initial surgical procedure[8]. Higher rates of positive margins are seen with less extensive surgical procedures. Many investigators have evaluated the impact of margin status on breast recurrence, and the results have been inconsistent[14,15,16,18,23,24,25,26,27,28]. As shown in Table 2, in three studies the risk of recurrence was not adversely affected by positive margins; in two series there was a slightly higher risk of breast recurrence with positive margins; and in four series the risk of recurrence was significantly higher in patients with positive resection margins.

Why do positive margins adversely affect local control in some series and not in others? As outlined by Solin, et al., appropriate patient selection is imperative. In their experience, in which local failure was less likely with positive margins, only patients with focally positive mar-

Table 2

Breast recurrence by margin status

	Percent Breast Failure	
Study	Margin Positive	Margin Negative
Bartelink (16)	6%	2%
Clarke (18)	9%	4%
Hunig (25)	7%	7%
Jones (28)	12.5%	1.5%
Ryoos (27)	13%	6%
Schmidt-Ullrich (26)	0%	0%
Solin (24)	5%	7%
Zafrani (15)	25%	8%
Kurtz (14)	21%	5%

gins were accepted for radiotherapy without re-excision. Further surgery was advised in patients with grossly positive or diffusely positive margins. Moreover, dose modification appears to be key, as shown by Schmidt-Ullrich, et al. In their experience breast failure was not affected by the status of the margin because the dose was adjusted by the margin status, i.e., 6000 cGy for negative margins, 6500 cGy for close margins, and 7000 cGy for positive margins. Conversely, in the series of Jones, et al. where there was no dose modification the incidence of recurrence was influenced by margin status. In our experience with 511 patients with 519 Stage I and II breast cancer treated with breast conserving surgery and RT, the usual dose for patients with negative margins was 5750 to 6000 cGy, whereas for those with positive or close margins, 6500 - 6800 cGy was administered. We observed no difference in crude breast relapse as determined by pathologic margin status: 6.6%, 5.5%, and 8.7% with positive or close, negative, and unknown margins, respectively. Lastly, if positive margins are encountered, a supplemental boost is imperative. Ryoos, et al. found that breast recurrence was significantly reduced in patients with positive margins in whom a boost was used (7%), versus 30% (3 of 10 patients) in those in whom the margin was positive and a boost was not utilized[27].

Optimally, all patients should have segmental mastectomies yielding negative microscopic margins. However, if the margins are focally positive, the management options include: 1) mastectomy, 2) re-excision, or 3) no further surgery, but modification of the radiation therapy boost. More extensive surgery appears to increase local control[8,29], yet may compromise cosmesis[29,30,31], and mastectomy, obviously, yields the poorest cosmetic outcome. Modification of the RT boost appears to enhance local control, and in our opinion, is less likely to adversely impact cosmesis. If the margins are grossly or diffusely positive, re-excision or mastectomy is advised.

INTERACTION AND SEQUENCING OF CONSERVATIVE SURGERY, CHEMOTHERAPY AND RADIATION

Both prospective as well as retrospective series have consistently demonstrated that the addition of chemotherapy to breast irradiation enhances local control[3,4,33,34,35,36,37], as shown in Table 3. Moreover, Rose, et al. has shown that adjuvant chemotherapy can enhance local control even in patients who are at high risk for local failure, such as those with extensive intraductal component. In their series when EIC was present and no adjuvant chemotherapy was given, the rate of breast failure was 30%, versus 13% if adjuvant chemotherapy was administered. To note, some investigators, but not all, have shown that chemotherapy may be detrimental to cosmesis[38,39,40]. Whether chemotherapy, given its cost and potential for complications[41,42], should be given solely to enhance local control is debatable. Although breast failure is a devastating event for the individual patient, chemotherapy is probably not cost effective in this setting.

The appropriate sequencing of chemotherapy and radiation therapy has received attention recently[43]. In the report of Recht, et al., chemotherapy was given before, after, or concurrently with radiation therapy, or in a sandwich technique (two cycles of chemotherapy, followed by radiation therapy, followed by further chemotherapy). When the entire course of chemotherapy was given first, often times there was a significant delay between surgery and the initiation of radiation. The 5-year actuarial rate of breast recurrence was 35% if radiation therapy was delayed for more than 16 weeks, versus 5% if the radiotherapy began within this time period (p = 0.0001).

Table 3

Incidence of brest failure by systemic therapy in addition to RT

		Percent Breast Failure	
Study	Type of Systemic Therapy	RT + Systemic	RT Alone
Haffty (33)	CMF and/or Tamoxifen6%	6%	13%
Solin (34)	CMF +/- P	3%	8%
Rose (35)	CMF/CAF%	5%	17%
Rutquist (36)	Tamoxifen12.5%	5%	9%
Perez (37)	CMF/CAF and/or Tamoxifen13%		
	T1	0%	15%
	T2	10%	23%
Fisher (4)	Mephalan + 5FU	6%	12%
Lichter (32)	AC	7%	13%

Other series, however, have not confirmed these findings[44,45]. In NSABP-15, women with lymph node positive, amoxifen-nonresponsive, breast cancers undergoing either modified radical mastectomy or breast conservation therapy were randomized to four cycles of doxycycline and cyclophosphamide given prior to radiation therapy, or one cycle of cyclophosphamide, methotrexate and 5-FU prior to radiation (followed later by more chemotherapy). The risk of breast recurrence, with a mean follow-up of 26 months, was 4% with delayed radiotherapy versus 3% when RT was initiated within six weeks of surgery. In NSABP-16, in which post-menopausal, lymph node positive, Tamoxifen-responsive, women were randomized to either one cycle of chemotherapy plus Tamoxifen versus four cycles of chemotherapy plus Tamoxifen, again no difference in the risk of breast recurrence was noted. In the patients with a significant delay, the recurrence rate was 0% versus 2% with a minimal delay.

What is the source of this discrepancy? The Harvard University series has a much longer follow-up; indeed the actuarial local control curve reveals that breast failures began to increase significantly after three years. The NSABP data may not be mature enough to draw definite conclusions. Clearly, this issue needs further study. In the meantime it may not be prudent to postpone radiotherapy beyond four months from surgery.

THE ROLE OF BREAST CONSERVATION IN PATIENTS WITH LARGE PRIMARY TUMORS

There is some debate as to the maximal size of breast cancer appropriate for BCT. All prospective and retrospective studies have included women with T1 primaries (< 2 cm.), and many have included T2 lesions (>2 cm. to 5 cm.)[13,16,17,18,19,46,47,32,37]. Although some have shown inferior control rates in T2 tumors, this is not universal, as shown in Table 4. Most would agree that women with cancers (< 2 cm). are candidates for BCT, but consensus regarding the larger primaries doe not exist[48,49]. Given the success of BCT in smaller tumors, its role in patients with larger tumors has been investigated. Three strategies to render large primaries amenable to BCT have been employed: preoperative radiotherapy, preoperative chemotherapy, as well as chemotherapy and radiation alone, with surgery reserved for salvage[46,47,48].

In a prospective trial which included women with stages I, II, and III breast cancer, Jacquillat and coworkers administered chemotherapy followed by radiation, reserving mastectomy for recurrence[50]. Over 75% tumor regression was observed in 41% (44% T1, 40% T2, 47% T3, and 38% T4). The estimated 5-year breast preservation for the entire group was 94%, with local-regional recurrence seen in 13% T2, 18% T3, and 19% T3. These authors reported excellent to good cosmetic results in the majority of patients, although significant fibrosis was seen in 20% and 35% of those with T3 and T4 tumors, respectively. In a series of 138 patients, of whom 57% had cancers greater than 4.5 cm. in greatest dimension, radiation was given preoperatively[51]. Depending upon the response, patients were to a) receive further radiation therapy (for a complete response), b) tumorectomy plus radiation boost (for a partial response), or c) modified radical mastectomy (for no response). Sixteen percent had a complete response to radiation therapy and went on to further RT without surgery. The 5-year local control in this group was 87%. Thirty-eight percent had a partial response and went on to lumpectomy. The 5-year local control in this group was 90%. In the cohort who did not respond and had mastectomy, 100% local control was achieved.

There has been more interest in preoperative chemotherapy rather than RT, however. Given the incidence of distant metastases and death from breast cancer in patients with large primaries, chemotherapy may provide

Table 4

Breast recurrence by tumor size

	Percent Breast Failure	
Study	T1 (less than 2 cm)	T2 (2.1 to 5 cm)
Clarke (19)	5.5%	2.8%
Fowble (47)	6%	6%
Lindley (13)	12%	12%
Eberlein (46)	18.5%	20.5%
Bartelink (16)	2%	2%
Delouche (18)	6%	14%
van Lindbergen (17)	5.2%	11.5%
Perez (37)	5%	45%
Locker (48)	15%	45%
Lichter (32)	10%	14%

the additional benefit of preventing the growth of micrometastases. Bonadonna, et al. reported initial data from a protocol employing primary chemotherapy to avoid mastectomy in tumors with diameters of 3 cm. or more[49]. Following incisional biopsy, three or four cycles of chemotherapy was administered. Those having no response went on to modified radical mastectomy. If the tumor was under 3 cm., quadrantectomy and axillary dissection followed by radiotherapy was performed. If the tumor was still 3 cm. or greater, modified radical mastectomy was advised. All drug regimens (CMF, FAC, and FEC) were found to be equally efficacious, resulting in complete or partial responses in 70 to 87%. Overall 88% of the patients were able to have breast conserving surgery, and all patients whose tumors were reduced to less than 3 cm. had negative margins. Tumor response was related to size: 93% of tumors initially 3 to 4 cm., 77% initially 4 to 5 cm., and 83% of those 5 to 6 cm. were rendered less than 3 cm. In contrast, only 29% of patients with tumors initially over 6 cm. were candidates for breast conserving surgery following chemotherapy. Tumor response was also associated with estrogen receptor status (66% response with ER positive tumors versus 81% response with ER negative tumors), and progesterone receptor status (59% response with PR positive tumors versus 84% response with PR negative tumors). Response did not correlate with age, menopause status, DNA content, or thymidine labeling index. The data was too immature to report recurrence rates.

At the present time the NSABP is also conducting a study of preoperative chemotherapy. This protocol will include patients with T1, T2, as well as T3 primary lesions.

THE ROLE OF RADIATION THERAPY FOLLOWING CONSERVATIVE SURGERY IN VERY SMALL PRIMARY CANCERS

Due to greater public awareness of the importance of early detection and screening mammography, occult and very small breast cancers are becoming more commonplace. Given the expense, the small but definite risk of radiation induced sequelae, and the logistical considerations of a 6-week course of breast irradiation, some have questioned the necessity for radiotherapy following conservative surgery for very small tumors. Greening, et al. conducted a prospective single arm study in 81 patients with tumors less than 2 cm., and located at least 2 cm. from the nipple, employing surgical resection without radiotherapy[52]. Only patients whose breasts were of sufficient size to permit excision of one-quarter to one-third of the breast were eligible. Surgical resection of 2.5 cm. of grossly normal tissue around the lump and negative axillary lymph nodes were mandated. The incidence of local failure for all patients within five years was 10%: in premenopausal women, the rate was 24% versus 12% for postmenopausal patients ($p < 0.05$). Moreover, 36% of patients under 47 years of age failed in the breast.

The Uppsala-Orebro Breast Cancer Study conducted a prospectively randomized trial comparing sector resection alone to sector resection followed by breast irradiation[53]. The study was limited to patients with tumors no more than 2 cm., negative nodes, and negative resection margins. It should be noted that this was a highly select group, as 50% of the patients initially thought to be candidates were eventually excluded. The probability of remaining free of breast recurrence at five years was over 95% in the group receiving radiation therapy versus 88% in those treated with surgery alone ($p = 0.063$). Survival was not different in the two arms.

Although in NSABP-06[54], the overall incidence of breast failure was significantly reduced by radiation therapy following segmental mastectomy, subset analysis revealed that at five years, the local failure in tumors one cm. or less, was unaffected by radiation (14% with segmental resection alone versus 11% with segmental mastectomy plus radiotherapy); at seven years that difference had increased [28% with surgery alone versus 11% with surgery plus radiotherapy[55]]. The NSABP is currently conducting a prospectively randomized trial in which patients with occult, invasive cancers < 1 cm. and negative axillary nodes are treated with lumpectomy with either breast irradiation, breast irradiation plus Tamoxifen, or Tamoxifen alone.

These studies suggest that surgery alone may be a viable option for patients with small breast cancers. Caution is advised in premenopausal women. More extensive local surgery may be necessary, as evidenced by the 10% local failure following removal of one-quarter to one-third of the breast in the Greening, et al. study. In the quest for local control without RT, cosmesis must not be forgotten. Six weeks of RT may be justified if it allows a less extensive resection and excellent cosmesis. Until further information is available for these most favorable breast cancers, radiotherapy following lumpectomy should be offered to patients if breast preservation is a desired goal. Breast recurrence does not appear to adversely impact survival[56].

SALVAGE THERAPY AFTER BREAST RELAPSE

Breast recurrences are seen in 5 to 15% of patients undergoing conservative surgery and radiation therapy[57,58,59,60,61,62]. Most recurrences are detected clinically, and usually arise in the vicinity of the original primary, although with time more are located elsewhere in the breast, suggesting that these may be new primaries. About 80% of local recurrences are operable. Ten percent are locally advanced, and 10% occur simultaneously or after distant metastases.

Salvage mastectomy has been most commonly employed, and has engendered 5-year survival rates ranging from 50% to 85%. Prognostic factors found to be significant are disease-free interval (time from BCT to failure), extent and site of the breast failure, and initial stage. Haffty, et al. has also studied flow cytometry and thymidine labeling index in a limited group of patients with local failure[63]; he found that patients with diploid and low S-phase fraction recurrences had the best 5-year overall and disease-free survival after breast recurrence (89% and 100%, respectively).

Recently some have questioned the feasibility of secondary breast conserving surgery following a local recurrence. Fowble, et al. and Schnitt, et al. examined salvage mastectomy specimens, and found that 60 to 80% of patients would have no residual cancer after salvage quadrantectomy[64,65]. Although several series include a few local failures successfully salvaged with a second wide local excision, the largest experience is that of Kurtz, et al[66]. Ninety-one patients underwent a second wide excision, and 85 underwent salvage mastectomy. Although there was some compromise of 5-year local control in the former group (62%) compared with those undergoing mastectomy (88%), there was no difference in 5-year cause-specific survival (77% with wide excision versus 69% with mastectomy). Kurtz found that disease-free interval and margins of the second wide local resection had a significant impact on the rate of third breast recurrence. He concluded that selected patients, i.e. those with a long disease-free interval and negative resection margins were candidates for salvage breast conserving surgery following breast recurrence.

CONCLUSIONS

1) Extensive intraductal carcinoma is not, in our opinion, an absolute contraindication to breast conservation therapy. Instead it is predictive of a greater residual burden of cancer within the breast following a limited excision. Adequate resection with negative microscopic margins is advised.

Adjuvant chemotherapy or Tamoxifen may be considered to enhance local control.

2) In patients without an extensive intraductal component and focally positive microscopic margins, either re-excision or breast RT including a boost to higher than usual radiation doses are appropriate. Re-excision or mastectomy is warranted if the margins are grossly or diffusely involved.

3) Chemotherapy and Tamoxifen appear to enhance local control. The addition of chemotherapy to radiation may, however, compromise cosmesis.

4) The optimal sequencing of conservative surgery, radiotherapy, and adjuvant chemotherapy is unknown. In one study a significant delay (greater than four months) in the initiation of radiation therapy was associated with an increased risk of breast recurrence.

5) Radiotherapy may be unnecessary in patients with very small invasive cancers. In our opinion, until further information is available, radiotherapy should be offered to patients if breast preservation is a desired goal.

6) The role of conservative surgery and radiotherapy in tumors over 5 cm. has not been established. A recent study suggests that preoperative chemotherapy may allow breast preserving surgery in these large cancers.

7) Mastectomy is considered the standard salvage procedure for isolated breast recurrences. However, a second breast conserving procedure may be appropriate in selected patients.

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Bilirubin Encephalopathy in a Term Infant After Planned Home Delivery

by Lisa L. Schroeder, M.D. and Timothy A O'Connor, M.D.

A term infant was delivered at home by his father after a pregnancy which involved no organized medical care. By the third day of life the infant developed fever, poor feeding and severe jaundice. The infant was found to have a serum indirect bilirubin of 49 mg/dl secondary to isoimmune hemolytic anemia due to anti-c antibody. The infant survived but suffers from clinical manifestations of kernicterus.

Bilirubin encephalopathy in the term newborn is a rare occurrence. The widespread use of anti-D gamma globulin has dramatically reduced the incidence of Rh (D) isoimmune hemolytic disease of the newborn over the last 20 years. Likewise, routine screening for minor group antibodies in pregnant women allows identification of pregnancies where isoimmune hemolysis may occur.

Increased mortality of infants born at home has been well documented, especially when those births were assisted by lesser trained attendants or were accompanied by a lack of prenatal care.[1,2] Little information exists on the incidence of significant morbidity in these situations, however.

This report describes a Missouri infant who suffered substantial neurological injury as a consequence of no medical care during pregnancy and childbirth.

CASE REPORT

A 3.5 kg infant was born at term to a 36 year old gravida 5, para 5 woman. The family did not seek prenatal care from a physician or midwife because of financial and religious reasons. The delivery was attended by the infant's father and was reportedly without complications.

On the second day of life, the family noted the onset of jaundice. On the third day the infant developed lethargy, poor breast feeding, and was thought to be febrile. The infant was taken to a local physician's office who, upon noting severe jaundice, referred the family to The Children's Mercy Hospital. Upon admission, the staff noted the infant's severe jaundice and moderate lethargy. The temperature, taken rectally, was 37.0 C, the respiration rate was 32 per minute, and heart rate was 146 per minute. The infant was noted to have repeated periods of apnea. The infant's temperature was 38.8 C three hours after admission.

Initial laboratory evaluation revealed blood type O, a positive direct Coombs test and a serum indirect bilirubin of 49 mg/dl. Antibody testing revealed anti-c antibody. A blood smear revealed no evidence of intravascular hemolysis. Blood, cerebrospinal fluid and urine cultures revealed no bacterial or viral pathogens. Intravenous antibiotics and acyclovir were begun empirically.

Two exchange transfusions and phototherapy were used to decrease the serum bilirubin over the next 12 hours. The infant continued to exhibit episodic apnea and developed hypertonia and focal seizures over the next two days. The seizures stopped prior to the infant's discharge. The episodic apnea persisted but improved with caffeine therapy.

Prior to discharge, computed tomography of the brain revealed no abnormalities. Electroencephalography revealed diffuse slowing and disorganization of the background rhythm. Brainstem auditory evoked response (BSAER) testing disclosed a bilateral neurosensory deficit.

An examination of the infant at five weeks of age revealed persistent hypotonia, poor feeding and an irregular respiratory pattern.

DISCUSSION

Acute bilirubin encephalopathy in term infants has become a rare disease. In an autopsy review between 1976 and 1982, only 2% of the cases of kernicterus involved term infants.[3] This is contrasted by earlier descriptions of kernicterus in which the majority of infants were term and suffered from severe hemolytic anemia.[4 5 6] Advances such as anti-D gamma globulin, routine screening of pregnant women for the presence of irregular circulating antibodies, and Coombs testing of infants born to mothers with blood type O have significantly reduced the incidence of unrecognized severe isoimmune hemolysis. Serum bilirubin levels in the range of this patient (49 mg/dl) are seen only in hemolytic processes.

This infant demonstrated the classic three-phased evolution of acute bilirubin encephalopathy. Infants who follow this pattern invariably develop features of chronic bilirubin encephalopathy including sensorineural hearing loss, extrapyramidal abnormalities and gaze abnormalities.[7]

A number of retrospective studies have shown an increase in infant mortality associated with home delivery, especially when the births occurred in association with no prenatal care and lesser trained attendants. These studies were made possible by linking of birth certificates with death certificates. No such mechanism is in place to monitor the incidence of neonatal morbidity associated with home births.

This infant sustained neurologic damage secondary to isoimmune hemolytic disease. It is likely that basic prenatal care or delivery in a hospital or birthing center would have lead to earlier intervention and prevented long term neurologic sequelae. This case reinforces the requirement for universal access to perinatal care.

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THOMAS P. DOYLE, M.D.

HOME: St. Louis, Missouri
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SPECIALTY: Orthopedic Surgery.
MEDICAL COLLEGE: University of Missouri, 1978
PRACTICE: "I recently purchased an established but declining sole practitioner office from a retiring physician. It's a risk, but they say that great deeds are usually wrought at great risk."
HOBBIES: Horseback riding and golf. "If I combined activities, would it be polo?"
LAST BOOK READ: Missouri: Images of Nature, photographed by Charles Gurche.
LATEST ACCOMPLISHMENT: "Testing a protective knee pad I'm developing for use by football players."
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Dear Dr. Woerth,

As a specialist I am frequently asked to serve as a consultant. Sometimes on these cases for which I consult, the patient may have a few symptoms of a disease but does not have the disease itself. If I don't enter some type of a diagnosis code for these consultations, of course, I will not be paid. Have you any suggestions as to how I might code for this situation?
Dr. M.S.

Dear Dr. M.S.,

There is a category of diagnostic codes that addressed this very situation. They are found in Volume 1 of the ICD-9 book in the section entitled V Code. The code category that you want to use is V71, Observation and evaluation for suspected conditions. I refer to this as a category rather than a code because V71 must have a fourth digit, and for some situations a fifth digit, in order to be a valid code.

The key to using the V71 category is found in the "Includes" note listed just under the category heading. It indicates that the category is to be used for "cases which present some symptoms or evidence of an abnormal condition which required study, but which after examination and observation show no need for further treatment or medical care." So in the case of a patient who has for example, symptoms of cardiovascular disease (chest pain and irregular heartbeat) but does not have cardiovascular disease, you would use the V71.7 code, Observation for suspected cardiovascular disease. It is important to also code the symptoms that the patient has, i.e. chest pain and irregular heartbeat, along with the appropriate V71 code. These symptoms are in fact the patient's diagnoses and should be listed as #1 and #2 on the claim form with the V71.7 code listed as #3. Your procedure code would be one of the consultation codes.

I often hear from clients that Medicare does not pay for claims with a V code as the diagnosis. This is not true. Medicare will pay when V codes are properly used. In order for a V code to be properly used, the notes such as the "Includes" or "Excludes" must be read and understood. In the case of V71, the patient must have symptoms or evidence of an abnormal condition (this establishes the medical necessity for a specialist) but after examination and observation show no need for further treatment. In other words, the patient does not have the disease for which the specialist was consulted and further treatment by the specialist is unnecessary.

The V71 category truly covers every possible suspected condition for which a specialist might be consulted. For the psychiatrist, there is V71.0, Observation for suspected mental condition. Notice that these are the only V71 codes requiring the fifth digit because they are further divided into adult and childhood antisocial behavior and other suspected mental conditions. For the oncologist, there is the code V71.1, Observation for suspected malignant neoplasm. The catch-all code is V71.8, Observation for other specified suspected conditions. When this code is used, the physician should include a note with the claim, or with electronic claim in the "comments" box, explaining what the suspected condition was.

Avoid using the code V71.9, Observation for unspecified suspected condition as use of it will result in a payment denial. Here is the rationale behind an insurance company's decision not to pay on this code. Because the patient's condition has not been determined, i.e. it is unspecified, it is impossible to know which medical specialist to consult. So until a medical problem is defined in the very general terms that this category allows (mental, tuberculosis, cardiovascular, accident) then a medical specialist's services are deemed inappropriate.

IMPORTANT NOTE: I know many of you have been receiving information in the mail about the ICD-10 book that is now available. I would recommend that you do **not** purchase this book. First, the book has not been modified for use in the medical office. That book will be titled ICD-10-CM. Second, Medicare will not be requiring ICD-10-CM for several years and will give you plenty of notification when the change from ICD-9-CM to ICD-10-CM will take place.

Dear Dr. Woerth,

At one of your seminars I attended, you recommended that all offices have a policy manual for employees which lists the policy for vacation, maternity leave, how salary increases are earned, etc.. My question is about sick leave. How many days should be allowed each year?
Dr. K.K.

Dear Dr. K.K.,

The standard sick leave allowed employees is one-half day for each month the employee has worked. Generally employees are allowed to accrue sick leave and I suggest there be a limit of 21 days. After 21 days, the employee should be paid for sick days not used. If

Continued on page 746

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Continued from page 745

the office policy regarding sick leave is "use it or lose it," it rewards the employee who is sick and encourages employees to call in sick when they are not. It also provides no incentive for staying healthy and never missing work for reason of illness. The limit of 21 days accrual of sick leave allows the employee who may need surgery or have an extended illness (hopefully) enough time to recover. You may wish to allow for a greater accrual of sick leave like 30 days but I highly encourage you to set a limit on this accrual. If, for example, an employee is allowed to accrue 60 days of sick leave and uses that sick leave all at one time, your office will be without an employee for 12 weeks. In most offices in which I consult, a 12 week absence of an employee would be a tremendous burden on the office, if not an unacceptable situation.

Do you have a question for Dr. Woerth? Include your questions along with your name, address and phone number and send them to:

Janice K. Woerth, Ph.D.
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Although your name will not be used in *Missouri Medicine,* please include your name and phone number so that Dr. Woerth may contact you if she needs additional information to answer your question.

Get Someone To Cover For Half An Hour

by Maria Evans, M.D., MSMA-RPS Chairperson

Most of Missouri's resident physicians already know the power of political influence through recent federal student loan legislation. The officials we elect make decisions that affect each of our lives daily--not just through student loans, but decisions affecting the very essence of the practice of medicine in our state. In the last state legislative session alone, bills were introduced covering topics from universal health care to lay midwifery. Most of the bills that didn't pass will be re-introduced next year. The people we elect will be voting upon those bills, and affecting your medical practice.

Sadly, Missouri's physicians do not even match up with the generally poor national voting trends. In 1988, 79.1% of Americans with four years or more of college voted in the presidential election. Unfortunately, only 49% of Missouri's 11,000 physicians are presently registered to vote, and experts estimate only half of that 49% will actually vote. Another distressing figure is the percentage of voters in the 25-44 year old age group--the age group that encompasses most residents. Only 53.9% of this age group voted in the 1988 presidential election. It's not hard to imagine that busy resident working 100+ hours per week won't even be able to make that figure.

In the meantime, people with less information and less education will be voting without you. "Cause" voters and "one-issue" voters will be showing up at the polls in droves, shaping party platforms in a way that may not be best for the future of health care in America.

Your vote really does matter. All the resident physicians in the state could make a difference. Voter registration tables are at malls everywhere. Take time and fill out a card. Perhaps a phone call to your local election authority could result in a voter registrar's appearance at your housestaff lounge or hospital lobby!

Finally, on election day, make a special effort to cover for each other for just a half an hour--just enough time for most folks to go vote. If you know you're going to be on a tough service, call now to vote absentee. It's as easy as a phone call and a stamp. You really can make a difference!

The last day to register to vote is **October 14**. Election day is **November 3**.

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In 1776 - English was chosen over German as the official language of the United States by the margin of one vote.

In 1845 - A single vote brought Texas into the union.

In 1868 - One vote saved Andrew Johnson from impeachment.

In 1876 - Rutherford B. Hayes won the presidency from Samuel Tilden by one vote.

In - 1923 - Adolf Hitler gained control of the Nazi Party by a single vote.

In 1948 - Lyndon B. Johnson was elected to the U.S. Senate from Texas by less than a vote per precinct.

In 1960 - John F. Kennedy beat Richard Nixon by an average of a single vote per precinct.

In 1982 - James R. Thompson was re-elected governor of Illinois by less than one vote per precinct.

"How Important is One Vote? Some Historic Facts" appeared in the *St. Louis Post-Dispatch*, Sunday, September 13, 1992, p. 12F, and was taken from James Lewis' fact sheet. Lewis is executive director of the East St. Louis Board of Election Commissioners.

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❖ **Douglas W. Beal, M.D.,** Green Meadows Clinic, UMC, Dept. of Child Health, Columbia, MO 65203, has become a member of the Boone County Medical Society. Dr. Beal received his medical degree at the Chicago Medical School, N. Chicago, IL, in 1980. He completed his residency at the University of Iowa Hospital and Clinics. Dr. Beal specializes in pediatrics.

❖ **Christopher M. Bieniek, M.D.,** 2727 St. Mary's Ave., Hannibal, MO 63401, has become a member of the Northeast County Medical Society. Dr. Bieniek received his medical degree at the Chicago Medical School, N. Chicago, IL, in 1986. He completed his residency at Monmouth Medical Center, Long Branch, NJ. Dr. Bieniek specializes in orthopedic surgery.

❖ **Thomas P. Bocchini, M.D.,** St. Louis University Hospital, Dept. of Radiology, Vista at Grand, St. Louis, MO 63110, has become a member of the Missouri State Medical Association. Dr. Bocchini received his medical degree at St. Louis University School of Medicine in 1986. He completed his residency at the University of Arizona, Tucson, AZ. Dr. Bocchini specializes in interventional radiology.

❖ **Stuart J. Braverman, M.D.,** 1718 S. Ingram, Sedalia, MO 65301, has become a member of the Pettis County Medical Society. Dr. Braverman received his medical degree at Tufts University, Boston, MA, in 1987. He completed his residency at Emory University Affiliated, Atlanta, GA. Dr. Braverman specializes in general surgery.

❖ **Barbara A. Caciolo, M.D.,** 6651 Chippewa #301, St. Louis, MO 63109, has become a member of the St. Louis Metropolitan Medical Society. Dr. Caciolo received her medical degree at St. Louis University School of Medicine in 1985. She completed her residency at The Jewish Hospital of St. Louis. Dr. Caiolo specializes in internal medicine.

❖ **Steven L. Coulter, M.D.,** 2301 Main, One Pershing Square, Kansas City, MO 64108-2428, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Coulter received his medical degree at the University of Oklahoma, Tulsa, OK, in 1978. He completed his residency at the University of Oklahoma. Dr. Coulter specializes in internal medicine.

❖ **James L. Fletcher Jr., M.D.,** 69 Doctors Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. Fletcher received his medical degree at Vanderbilt University School of Medicine, Nashville, TN, in 1976. He completed his residency at the University of Connecticut, Hartford, CT. Dr. Fletcher specializes in family practice.

❖ **John M. Gerdes, D.O.,** 11133 Dunn Rd., St. Louis, MO 63136, has become a member of the St. Louis Metropolitan Medical Society. Dr. Gerdes received his doctorate of osteopathy at the Kansas City College of Osteopathic Medicine, Kansas City, MO, in 1970. He completed his residency at the University School of Medicine, St. Louis. Dr. Gerdes specializes in emergency medicine.

❖ **James M. Glass, M.D.,** 401 Keene St., Columbia, MO 65201, has become a member of the Boone County Medical Society. Dr. Glass received his medical degree at the University of Utah School of Medicine, Salt Lake City, UT, in 1986. He completed his residency at the University of South Dakota, Sioux Falls, SD. Dr. Glass specializes in cardiovascular disease.

❖ **Theodore J. Grieshop, M.D.,** 14 Doctors' Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. Grieshop received his medical degree at Ohio State University, Columbus, OH, in 1987. He completed his residency at the Medical College of Ohio, Toledo, OH. Dr. Grieshop specializes in infectious diseases.

❖ **Joe E. Himes, M.D.,** 1520 S. Brentwood Blvd., St. Louis, MO 63144, has become a member of the Missouri State Medical Association. Dr. Himes received his medical degree at the University of Oklahoma, Tulsa, OK, in 1986. He completed his residency at the University of Oklahoma. Dr. Himes specializes in family practice.

❖ **Michael J. Jessup, M.D.,** 55 Doctor's Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. Jessup received his medical degree at the University of Arkansas, Little Rock, AR, in 1988. He completed his residency at Wesley Medical Center, Wichita, KS. Dr. Jessup specializes in obstetrics-gynecology.

❖ **Patrick E. Johnson, M.D.,** 301 W. Liberty, Farmington, MO 63640, has become a member of the Mineral Area Medical Society. Dr. Johnson received his medical degree at St. George's University, Grenada, West Indies, in 1983. He completed his residency at the Medical Center Hospital, Conroe, TX. Dr. Johnson specializes in family practice.

❖ **William L. Kincaid, M.D,** 634 North Grand, P.O. Box 14702, St. Louis, MO 63178, has become a member of the St. Louis Metropolitan Medical Society. Dr. Kincaid received his medical degree at St. Louis University School of Medicine in 1975. He completed his residency at the University of Texas Health Science Center, San Antonio, TX. Dr. Kincaid specializes in rhematology.

Continued on page 750

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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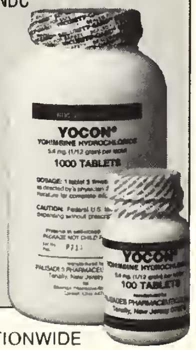

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Continued from page 749

❖ **Robert Lemery, M.D.,** Suite 2000, 4330 Wornall, Kansas City, MO 64111, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Lemery received his medical degree at the University of Sherbrooke, Sherbrooke, Canada, in 1979. He completed his residency at the Royal Victoria Hospital, Montreal, Quebec, Canada. Dr. Lemery specializes in internal medicine and cardiovasular diseases.

❖ **Mari A. McGoff-Fahrner, M.D.,** 226 S. Woods Mill Rd., Chesterfied, MO 63017, has become a member of the Missouri State Medical Association. Dr. Fahrner received her medical degree at the University of Alabama, Birmingham, AL, in 1985. She completed her residency at Barnes Hospital, St. Louis. Dr. Fahrner specializes in surgery.

❖ **Michael L. Madden, M.D.,** 7900 Lee's Summit Rd., Kansas City, MO 64139, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Madden received his medical degree at Louisiana State University Medical School, New Orleans, LA, in 1967. He completed his residency at Lafayette Charity Hospital, Lafayette, LA. Dr. Madden specializes in family practice.

❖ **Harvey L. Mirly, M.D.,** 1 Barnes Hospital, Suite 11300, St. Louis, MO, has become a member of the Missouri State Medical Association. Dr. Mirly received his medical degree at Loyola University, Stritch School of Medicine, Chicago, IL, in 1987. He completed his residency at the Ohio State University Hospitals, Columbus, OH. Dr. Mirly specializes in orthopedics.

❖ **John G. Neely, M.D.,** 517 S. Euclid Ave., Box 8115, St. Louis, MO 63110, has become a member of the Missouri State Medical Association. Dr. Neely received his medical degree at the University of Oklahoma, Oklahoma City, OK, in 1965. He completed his residency at Baylor College, Houston, TX. Dr. Neely specializes in otolaryngology.

❖ **Mary L. Nielsen, M.D.,** 621 S. New Ballas, St. Louis, MO 63141, has become a member of the Missouri State Medical Association. Dr. Nielsen received her medical degree at the University of Illinois College of Medicine, Urbana, IL, in 1988. She completed her residency at St. Louis University Medical Center. Dr. Nielsen specializes in psychiatry.

❖ **Stephen E. Peterson, M.D.,** 911 Main, Suite 2330, Kansas City, MO 64105, has become a member of the Missouri State Medical Association. Dr. Peterson received his medical degree at St. Louis University School of Medicine in 1986. He completed his residency at Karl Menninger School of Psychiatry, Topeka, KS. Dr. Peterson specializes in psychiatry.

❖ **Timothy F. Reed, M.D.,** 1513 Union Ave. #2300, Moberly, MO 65270, has become a member of the Chariton-Macon-Monroe-Randolph County Medical Society. Dr. Reed received his medical degree at the University of South Alabama, Mobile, AL, in 1989. He completed his residency at the University of Missouri-Columbia. Dr. Reed specializes in pediatrics.

RESIDENTS

St. Louis University
John M. Buergler, M.D., *Internal Medicine*
Kendall A. Itoku, M.D., *Urology*
Myles B. Koby, M.D., *Radiology*
Eduardo W. Quesada, M.D., *General Surgery*

STUDENTS

University of Missouri-Columbia
Lauren Blackwelder
Sally A. Bomar
Sharla M. Brown
William C. Bryant
Stephanie Carron
Candise Cope
Daniel J. Coy
Jill Henley
Robert B. Hibbard
Sara Holland
Rebecca Kelley
David A. Kropf
Joel R. Lane
Joel P. McKinsey
Timothy M. Miller
Oscar D. Norton
Eric W. Nottmeier
David R. Olson
Susan Pereira
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IN MEMORIAM

■ **Arnold V. Arms, M.D.,** Leawood, Kansas, died August 25, 1992, at age 79. Dr. Arms received his medical degree at Thomas Jefferson University, Philadelphia, Pennsylvania, in 1939. He practiced internal medicine and retired as a partner of Arms, Dodge, Robinson, Wilber and Crouch, Inc. in 1977. He had served on the executive staff of St. Luke's Hospital. He was an associate in medicine and a lecturer on medical history at the University of Kansas School of Medicine from 1942 to 1972. Dr. Arms was an emeritus associate at the school. He was also a clinical professor of medicine for the University of Kansas City School of Dentistry. Dr. Arms was a member of the Jackson County Medical Society, Missouri State Medical and American Medical Associations, past president of the Kansas City Academy of Medicine, a fellow of the American Society of Internal Medicine, a life member of the American College of Physicians, and a fellow of the St. Luke's Hospital Education and Research Foundation.

■ **Richard R. Cohle, M.D.,** Carthage, Missouri, died August 15, 1992, at age 66. Dr. Cohle received his medical degree at Washington University Medical School in 1948. Following residency at St. Louis County Hospital and the Veteran's Administration, he began his practice in Carthage. He practiced internal medicine from 1954 until retirement in 1988. Dr. Cohle was a member of the American Society of Internal Medicine and the American College of Physicians.

■ **Donald E. Heins, M.D.,** St. Joseph, Missouri, died July 1, 1992 at age 64. Dr. Heins received his medical degree at the University of Nebraska Medical School in 1953. He served his radiology residency at the San Antonio School of Medicine. He served with the Navy during World War II and the Army Medical Corps during the Korean War at Schofield Army Barracks, Hawaii. Dr. Heins was a family practitioner for 18 years in Texas. He became a board-certified radiologist in 1975 and was currently serving with the Professional Radiology of St. Joseph.

■ **Morris A. Mueller, M.D.,** San Antonio, Texas, died July 29, 1992, at age 87. A native of St. Louis, Dr. Mueller received his medical degree at the University of Munich, Germany in 1933. He served in New Guinea during World War II. He was a reserve officer in the Army before retiring as a colonel in 1968. He served as a surgeon for the 102nd Infantry Division, a reserve division in St. Louis. Dr. Mueller was a general practitioner in St. Louis from 1934 until his retirement in 1970.

■ **Donald R. Reimer, M.D.,** Jackson, Missouri, died July 11, 1992 at age 57. Dr. Reimer received his medical degree at the University of Colorado in 1962. From 1966 to 1968 he served as staff anesthesiologist, assistant chief and chief at the United States Naval Hospital in Chelsea, Massachusetts. At this time he was also an associate professor of anesthesiology at Boston University School of Medicine. Dr. Riemer then served as chief of anesthesiology at the United States Naval Hospital in Key West, Florida. In 1969 he began practice as anesthesiologist in Cape Girardeau. From 1971 to 1974 he served a residency in psychiatry at the Menninger Foundation in Topeka, Kansas, attaining distinguished scientific writing awards all three years. He also served as a staff psychiatrist at the Menninger Foundation and the Veterans Administration in Topeka. Dr. Reimer was chief of anesthesiology in Topeka from 1975 to 1980. In 1980 he returned to Cape Girardeau where he performed psychiatric, neuropsychiatric and general medical evaluations for Missouri and Illinois Social Security Services. He also served as psychiatrist for Lutheran Family and Children Service.

■ **John E. Yannakakis, M.D.,** Town and Country, Missouri, died August 20, 1992, at age 61. Dr. Yannakakis received his medical degree at the University of Athens, Greece, in 1957. He was an obstetrician and gynecologist in private practice for 30 years in Florissant. He was on staff at Christian Northeast and Northwest Hospitals and at DePaul Health Center. Dr. Yannakakis was also an assistant clinical professor at St. Louis University. He was a member of the International College of Surgeons and the American College of Obstetrics and Gynecologists.

FILLING THE GAP: MU Residency Program Provides Family Physicians for Missouri

Creating an interest in family practice especially in rural areas is a challenge because of high expectations from patients, low reimbursements, fewer insured people and few obstetrics providers.

The family medicine residency program at the University of Missouri-Columbia is the largest in Missouri. It has trained 174 residents, among the highest numbers in the country. New physicians from 40 states have come to MU for family practice residencies. Sixty percent of the graduates go into rural practice and more than 40 percent are now practicing in Missouri. About 20 percent of the graduates have gone into teaching roles, an area of shortage.

The program is successful for many reasons. Rather than being thrown into a frantic pace of on-call duty, residents begin their first month in an orientation that focuses on understanding interpersonal relationships as well as more traditional clinical topics.

Because the practice of family medicine requires expertise drawn from many clinical and basic science disciplines, residents begin specialty rotations after the first month. They spend time on internal medicine and general pediatrics wards, in neonatal intensive care units, in obstetrics/gynecology, general surgery and in the family practice inpatient service -- all in the first year.

During the second and third year residents continue specialty rotations but add block-time rotations in the rural areas of Fayette or Fulton, where they manage inpatient services and build their continuity practice.

A new attraction for students becoming family practitioners is the integrated residency program. It is a pilot program that began this July in which two fourth-year students were chosen to begin their residency work while finishing their graduation requirements. While the program does not shorten the coursework, it enables students to have more flexibility later on.

One of the most important and gratifying components of the residency program is the partnership system. In the system, two residents jointly assume patient-care responsibilities during in-hospital specialty rotations and in the ambulatory family practice setting. This system facilitates development of a large continuity family practice by allowing residents clinic time with their patients that is free from competing demands. One partner is always available for ward duties and to cover patients when the other has conferences or needs a break. The experience of working with a partner around call schedules and patients provides an excellent model for future practice.

The family practice residency program's large patient base provides plenty of clinical experience. Annual visits to MU's family medicine services alone number 50,000, with 1,300 admissions, 300 obstetrical deliveries and 3,100 emergency room visits. (Missouri Medical Review Photo)

University of Missouri - Columbia

Giulio Barbero, M.D.

Giulio Barbero, M.D., professor emeritus of child health, was named chairman of the International Cystic Fibrosis Association's scientific committee in August. His job will be to set up CF programs throughout the world and to develop a plan for professional and lay education and research into the disease.

Dr. Barbero's appointment is for a three-year term. He will continue teaching and medical practice at the MU Health Sciences Center during this time.

Javad h. Kashani, M.D., professor of psychiatry and child health, received a 1992 Exemplary Psychiatrist Award for dedication and devotion to patients with serious mental illnesses. The National Alliance for the Mentally Ill presents such awards annually to a limited number of psychiatrists throughout the United States.

Washington University

Edward Geltman, M.D., associate professor of medicine, served as a co-investigator for an international study reporting beneficial effects for heart attack patients using the drug captopril.

The study found that when captopril is first administered within three to 16 days after a heart attack, the rates of mortality, subsequent heart attacks, adverse cardiovascular events is reduced.

The Survival and Ventricular Enlargement (SAVE) Study was conducted between 1987 and 1992, on 2,231 men and women at 45 centers and 112 participating hospitals throughout the United States and Canada.

Henry J. Kaplan, M.D., chairman of the Department of Ophthalmology and Visual Sciences, has received a grant from Research to Prevent Blindness (RPB).

The grant supports research into the causes, treatment and prevention of diseases that cause blindness.

Joel Perlmutter, M.D., associate professor of neurology and research associate professor of radiology, received the Shannon award from the National Institute of Neurological Disorders and Stroke. The two-year award will fund a study of dystonia, a movement disorder characterized by muscle spasms that produce abnormal movements and postures.

Dr. Perlmutter will study a total of 60 patients and normal volunteers. The dystonia patient group will include those with writer's cramp, a disorder characterized by hand spasms, and those with blepharospasm, a disorder in which both eyes uncontrollably squeeze shut.

The study will research how increased dopamine activity in the brain may lead to difficulty controlling certain movements. Positron emission tomography (PET) scanning, an imaging technique developed at Washington University, will be used to study various parts of the brain believed to be active in causing dystonia.

In other research, Dr. Perlmutter is testing an experimental drug called lazabemide in patients with the early stages of Parkinson's Disease. Lazabemide is designed to slow the development of symptoms rather than to treat the symptoms.

Persons interested in volunteering for either the dystonia or Parkinson's study should call Washington University School of Medicine at (314)362-6909.

Washington University has received a contract from the NIH's National Heart, Lung and Blood Institute to coordinate a multi-center study of heart disease in nearly 15,000 families.

The study is designed to help explain how a person's genes and family environment work together to cause heart disease. It will be the first to examine both factors together comprehensively in such a large group.

The four-year contract is part of a collaboration among five universities. Washington University will coordinate the study and analyze data gathered by investigators at the four field centers. **Dabeeru C. Rao, Ph.D.,** professor and director of the Division of Biostatistics, and **Michael A. Province, Ph.D.,** assistant professor of biostatistics, will lead the St. Louis team.

Researchers at Washington University School of Medicine received a three-year grant from the National Institute on Aging to study how driving performance changes with time and age and how Alzheimer's disease may affect driving ability.

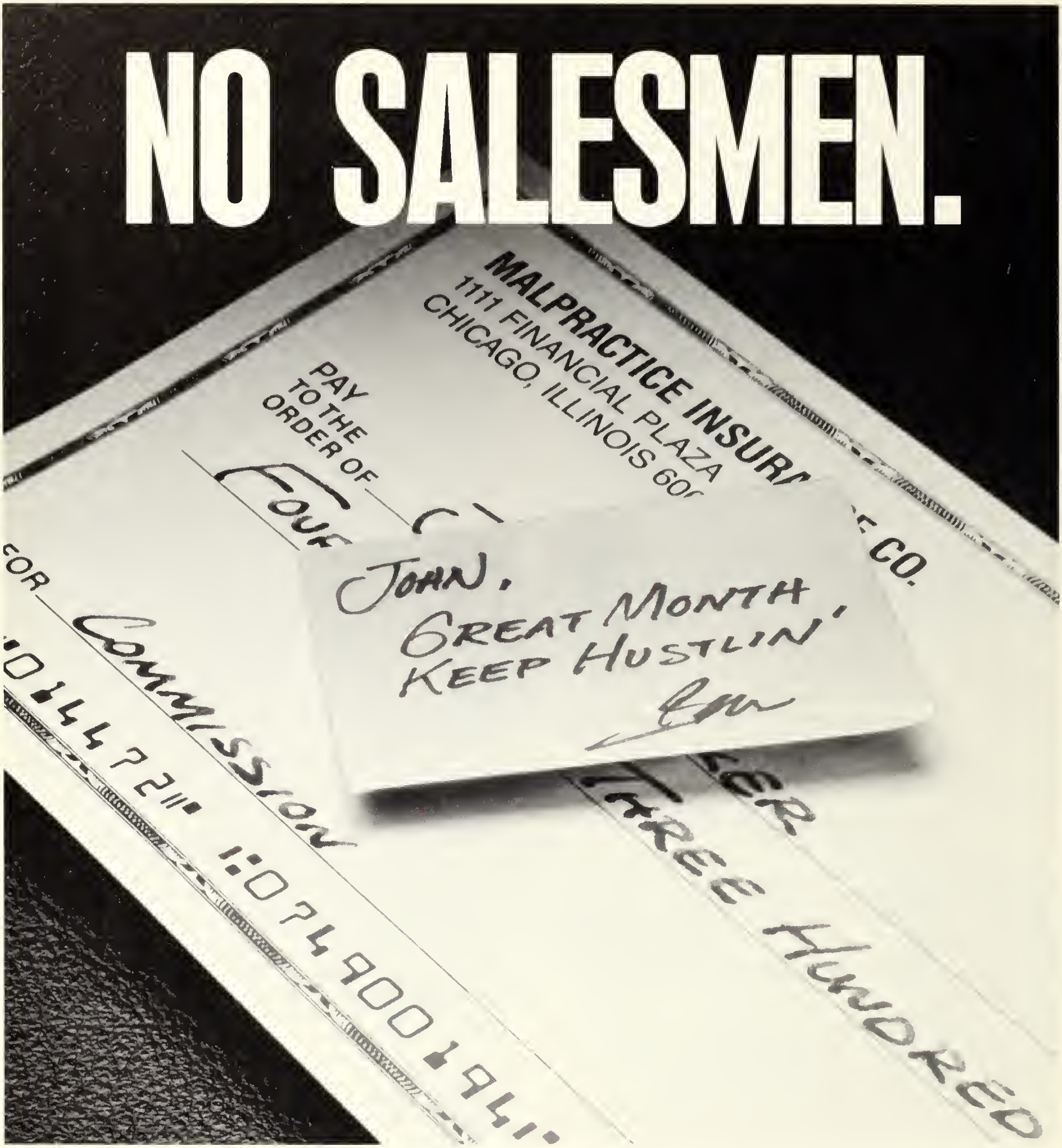
John Morris, M.D., associate professor of neurology, and **Linda Hunt**, instructor of occupational therapy, will be the principal investigators for the study. The research will help determine when patients with Alzheimer's disease should stop driving. It will also provide useful information for establishing public policy regarding driving competency and license-renewal intervals for the elderly.

Participants in the study will take a series of tests to evaluate memory and cognitive function and be asked questions about how they perceive their driving ability. They will complete a one-hour road test and undergo a series of neurological, visual and motor control tests. Skills such as maintaining vigilance, switching attention and paying attention to multiple activities will be measured.

Washington University researchers are seeking twins to participate in a study to help determine genetic factors affecting vision.

Both fraternal and identical twins ranging in age from 12-80 will be examined to determine the shape of the cornea. A 45-minute exam will consist of a brief history, vision test and photograph of the eye. A prescription for glasses will be written if the exam indicates they are needed.

To qualify for the study, both twins must participate. For more information, call Jara Ives at the Washington University Eye Center, (314)362-3937.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2 & 3 - *St. Louis*: Occupational Allergic & Immunologic Disease. 9.5 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

2 to 4 - *Kansas City*: "Doctor Are You Healing or Dealing?" Contact the Missouri Association of Osteopathic Physicians & Surgeons, P.O. Box 748, Jefferson City, MO 65102. PH. 314/634-3415.

3 - *Kansas City*: Fourth Annual Surgical Symposium. Jointly sponsored with Truman Medical Center. 4 Category 1 credit hours. Contact Carol Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.

3 - *St. Louis*: Isolation of Human Hematopoietic Stem Cells, Stem Cell Expansion, and New Application of Growth Factors. 6 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

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5 - *St. Louis*: Images of the Mind: A Vision for Radiology. Wendell G. Scott Lecture by Marcus E. Raichle, M.D. For more information contact the Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110.

5 to 9 - *St. Louis*: The Medicolegal Death Investigator Training Course. 33 credit hours. Contact Mary Fran Ernst, St. Louis University School of Medicine, at 522-6410 ext. 6509.

7 to 10 - *Kansas City*: Issues in Minority Health Care. Contact Barry Kling, University of Missouri-Columbia School of Medicine, CME Office, MA215 Health Sciences Center,314/882-4105.

8 & 9 - *Tulsa, OK*: Depression: Phenomenology, Etiology and Treatment. Presented by the Laureate Psychiatric Clinic and Hospital. For more information call 800/322-5173 ext. 4094.

8 to 10 - *Columbia*: 35th Physicians Alumni Weekend. Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.

9 - *Kansas City*: Office Based Ultrasound for OB/GYN. 6 credit hours. Contact Carl Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.

9 - *Kansas City*: Challenges and Controversies in Emergency Care. Contact the Ed Bixby Institute for Postgraduate Medical Education, 9103 E. 39th St., Kansas City, MO 64133, 816/276-4306, in MO, 800/92-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.

13 & 14 - *St. Louis*: Transesophageal Echocardiography Course. 13 credit hours. Contact Dianne Reid, St. Louis University Medical Center, 314/577-8897.

15 - *St. Louis*: Pediatric Advanced Cardiac & Trauma Support & Pediatric Advanced Life Support Recert. Course. 7 credit hours. Contact the CME Office, St. University Medical Center, 314/577-5385.

15 - *St. Louis*: Smoking Cessation in the Primary Care Practice. 5.5 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in MO, 800/325-9862 Interstate.

15 to 19 - *Kansas City*: Protect Your Medical Practice: Effective Management of Abusable Medications. Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.

16 - *Kansas City*: Surgical Wound Infections. 6 credit hours. Contact the Ed Bixby Institute for Postgraduate Medical Education, 9103 E. 39th St., Kansas City, MO 64133, 816/276-4306, in MO, 800/92-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.

16 & 17 - *St. Louis*: Repetitive Injuries in the Workplace: Prevention, Management, ADA. 10 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

17 - *St. Louis*: Midwest Clinical - Molecular Cardiology Conference. 8.25 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

17 - *St. Louis*: Ophthalmic Microsurgery Workshop Series - Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic Keratotomy. 7 credit hours. Contact Dr. Assil, Bethesda Eye Institutue, St. Louis University Medical Center, 577-8264.

21 - *St. Louis*: Update in Cardiology: Cardiac Arrhythmias. 4 credit hours. Contact St. John's Mercy Medical Center, 615 S. New Ballas Rd., St. Louis, MO 63141-8277, 569-6290.

22 - *St. Louis*: The Thomas F. Maher Lecture in Radiology. 1 credit hour. Contact St. John's Mercy Medical Center, 615 S. New Ballas Rd., St. Louis, MO 63141-8277, 569-6290.

22 to 24 - *St. Louis*: Practical Anatomy &Surgical Technique Workshop: Temporal Bone Surgical Dissection - Exploring New Surgical Instrumentation with Midas Rex Hands-On Workshop. 16 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

23 & 24 - Chesterfield: Endoscopic & Lasery Surgery - Advances, Complications and Controversies. Contact Jean Henderson, Dept. of Education, St. Luke's Hospital Institute for Health Education, 232 S. Woods Mill Rd., Chesterfield, MO 63017, 314/542-4762.

23 & 24 - *Kansas City*: Lasers & Electrosurgery in General Surgical Practice. Contact Carol Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.

27 & 28 - *St. Louis*: Medical Management of HIV Disease. 9.5 credit hours. Contact Susan Wightman, R.N., Washington University School of Medicine, 314/362-2418 or 800/432-0448.

29 - *St. Louis*: Ethical Decision Making in the 1990's: Assessing Life Sustaining Interventions. 5 credit hours. Contact Mary Beth Foerstel, R.N., St. Louis University School of Medicine Elizabeth Hogan, 577-8195.

31 - *St. Louis*: Pediatric Immunology & Rheumatology for the Practitioner. 6.75 credit hours. Contact Office of CME, Wash-

Continued on page 758

Continued from page 757

ington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

31 - *Kansas City*: Recognition and Management of Parkinson's Disease for the Primary Care Physician. 3.75 credit hours. Contact Office of CME, University of Kansas Medical Center, Rainbow & Olathe Blvds., Kansas City, KS 66103, (913)588-4488.

November

2 to 4 - *St. Louis*: Pediatric Advanced Cardiac & Trauma Support & Pediatric Advanced Life Support Provider Course. 20 credit hours. Contact Mary Beth Foerstel, R.N., St. University Medical Center, 314/577-5385.

3 - *St. Louis*: Fall Panel Discussion: The use of monoclonal antibodies in gram negative sepsis. Contact St. Louis Surgical Society, John P. Hoehn, M.D., Secretary, 314/569-6656.

5 - *St. Louis*: 1992 Pediatric Trauma: The Kaliedescope of Care. 7 credit hours. Contact Laura Kuensting, B.S.N., St. Louis University Medical Center, 577-5666.

5 to 7 - *Kansas City*: 70th Annual Fall Clinical Conference. Contact Linda F. Smutz, Kansas City Southwest Clinical Society, 7920 Ward Parkway, Ste. 206, Kansas City, MO 64114, 816/523-3383.

5 to 8 - *St. Louis*: The International Society for Applied Cardiovascular Biology & Washington University School of Medicine, 3rd Bennial Meeting Toward Application of Advances in Basic Cardiovascular Biology. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in MO, 800/325-9862 Interstate.

6 - *Columbia*: OB/GYN Update 1992. Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.

6 & 7 - *Detroit, MI*: 40th Annual Detroit Trauma Symposium. Contact Marjorie Norum, Dept. of Surgery, Harper Hospital 3990 John R., Detroit, MI 48201, 313/745-8778.

6 to 8 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: Surgical Approaches to the Skull Base. 28 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

6 to 8 - *Rockville, MD*: Fourth Annual Infectious Disease Review. Contact, Svetlana Lisanti, Conference Coordinator, Center for Bio-Medical Communications, Inc., 80 West Madison Ave., Dumont, NJ 07628, 201/385-8080 or 800/231-0389.

9 - *St. Louis*: Transjugular Intrahepatic Porto-systemic Shunts (TIPS). City-Wide Radiology Conference by Ernest J. Ring, M.D. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

9 to 13 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: The 2nd Ugo Fisch Microsurgery of the Cranial Base Workshop. 40 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

10 to 12 - *St. Louis*: Doppler Echocardiography: The Quantitative Approach. 20 credit hours. Contact Dianne Reid, St. Louis University Medical Center, 314/577-8897.

12 & 13 - *Kansas City*: 10th Annual Basic and Advanced Fetal Heart Rate Monitoring Seminar. 13 credit hours. Contact Carl Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.

13 - *Kansas City*: Current Concepts in the Treatment of Breast Disease. 7 credit hours. Contact the Ed Bixby Institute for Postgraduate Medical Education, 9103 E. 39th St., Kansas City, MO 64133, 816/276-4306, in Missouri, 800/92-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.

12 to 15 - *San Antonio, TX*: Southern Medical Association 86th Annual Scientific Assembly. For more information SMA's Member Services Center at 800/423-4992 or 205/942-0642.

13 to 15 - *St. Louis*: Nineteenth Annual Symposium, Anesthesia and the Geriatric Patient. Contact Geriatric Symposium, Department of Anesthesiology, Box 8054, Washington University School of Medicine, 660 S. Euclid, St. Louis, MO 63110.

14 - *St. Louis*: Ophthalmic Microsurgery Workshop Series - Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic Keratotomy. 7 credit hours. Contact Dr. Assil, Bethesda Eye Institutue, St. Louis University Medical Center, 577-8264.

18 to 21 - *Madras, India*: 2nd International Meeting of the Royal College of Physicians and Surgeons Medicine & Surgery 2000 AD. 22 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

21 & 22 - *St. Joesph*: Advanced Cardiac Life Support Provider Course. 16 credit hours. Contatct Barb Tunks, R.N., Heartland Health System Critical Care Educator, 801 Faraon, St. Joseph, MO 64501, 816/271-7859.

21 to 23 - *St. Louis*: Advanced Neurosurgery Workshop for Operating Room Personnel. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

December

4 & 5 - *Kansas City*: Orthopedics for the Primary Care Physician. Category 1 credit hours not approved at this time. Contact Carol Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.

5 - *St. Louis*: Hypertension. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

8 & 9 - *St. Louis*: Transesophaeal Echocardiography Course. 13 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

10 to 12 - *St. Louis*: Missouri Cardiovascular. Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.

10 to 13 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: Craniofacial Surgery. 28 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

12 - *St. Louis*: Management of Hypercholesterolemia: Goals & Strategies. 4.5 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

14 - *St. Louis*: Trauma Imaging. City-Wide Radiology Conference by Stuart E. Mirvis, M.D. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

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Continued on page 760

Continued from page 759

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Manuscripts

Manuscripts should be typewritten, double-spaced, and the original with one copy submitted. Retain another copy for proofreading. Please number the pages of your manuscript. Manuscripts are not returned. Hospital and University appointments of the author(s) should accompany the manuscript. A synopsis-abstract of no more than 75 words should accompany the manuscript. Manuscripts may be submitted on 5 or 3 floppy disks using WordPerfect 5.1 or below.

References

References should be cited in numerical order in the text and arranged at the end of the article in the same order in which they are cited. The reference should give name of author, title of article, name of periodical, volume number, initial page number and year. Authors are responsible for reference accuracy.

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ADVERTISERS INDEX

Air Force	762
Army Reserve	710
CompHealth Locum Tenens	751
Eli Lilly & Co.	740
HealthCare Administrative Services	708
Healthline Management Inc.	718
Jackson & Coker	746
Medical Defense Associates	764
Medical Protective Company	756
MOMEDICO	706
MonetaMed	744
MSMA Foundation	728
NA & C	712
National Data Bank Response	760
Palisades Pharmaceuticals	750
Physicians' Health Committee	728
Physician International	751
PIE Mutual Insurance Co.	763
RCA Mutual Insurance	752
Sedgwick James of Missouri	748
TransAmerica	730

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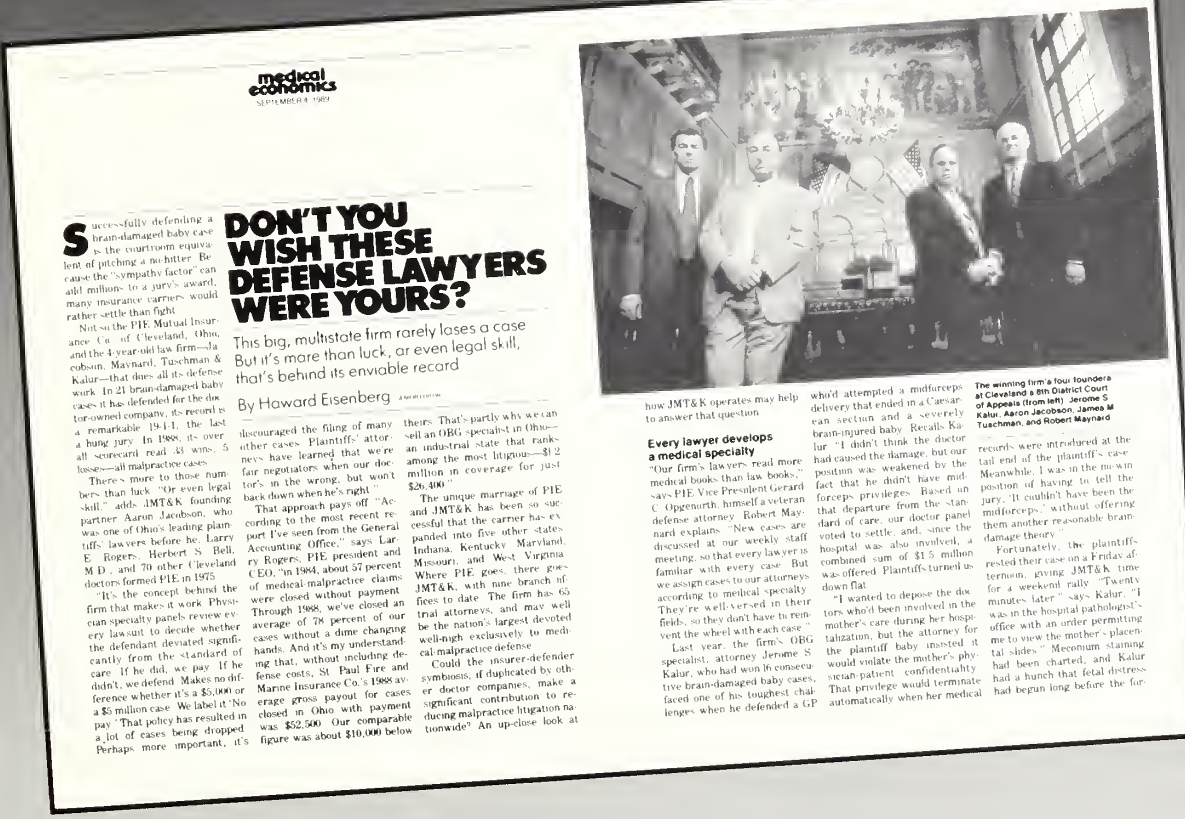

medical economics
SEPTEMBER 4, 1989

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record

By Howard Eisenberg SENIOR EDITOR

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the PIE Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988, its overall scorecard read 33 wins, 5 losses—all malpractice cases.

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed PIE in 1975.

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a $5,000 or a $5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, PIE president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was $52,500. Our comparable figure was about $10,000 below theirs. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—$1.2 million in coverage for just $26,400."

The unique marriage of PIE and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where PIE goes, there goes JMT&K, with nine branch offices to date. The firm has 65 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at how JMT&K operates may help to answer that question.

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says PIE Vice President Gerard C. Opgenorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP who'd attempted a midforceps delivery that ended in a Caesarean section and a severely brain-injured baby. Recalls Kalur: "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of $1.5 million was offered. Plaintiffs turned us down flat.

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical records were introduced at the tail end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain-damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-

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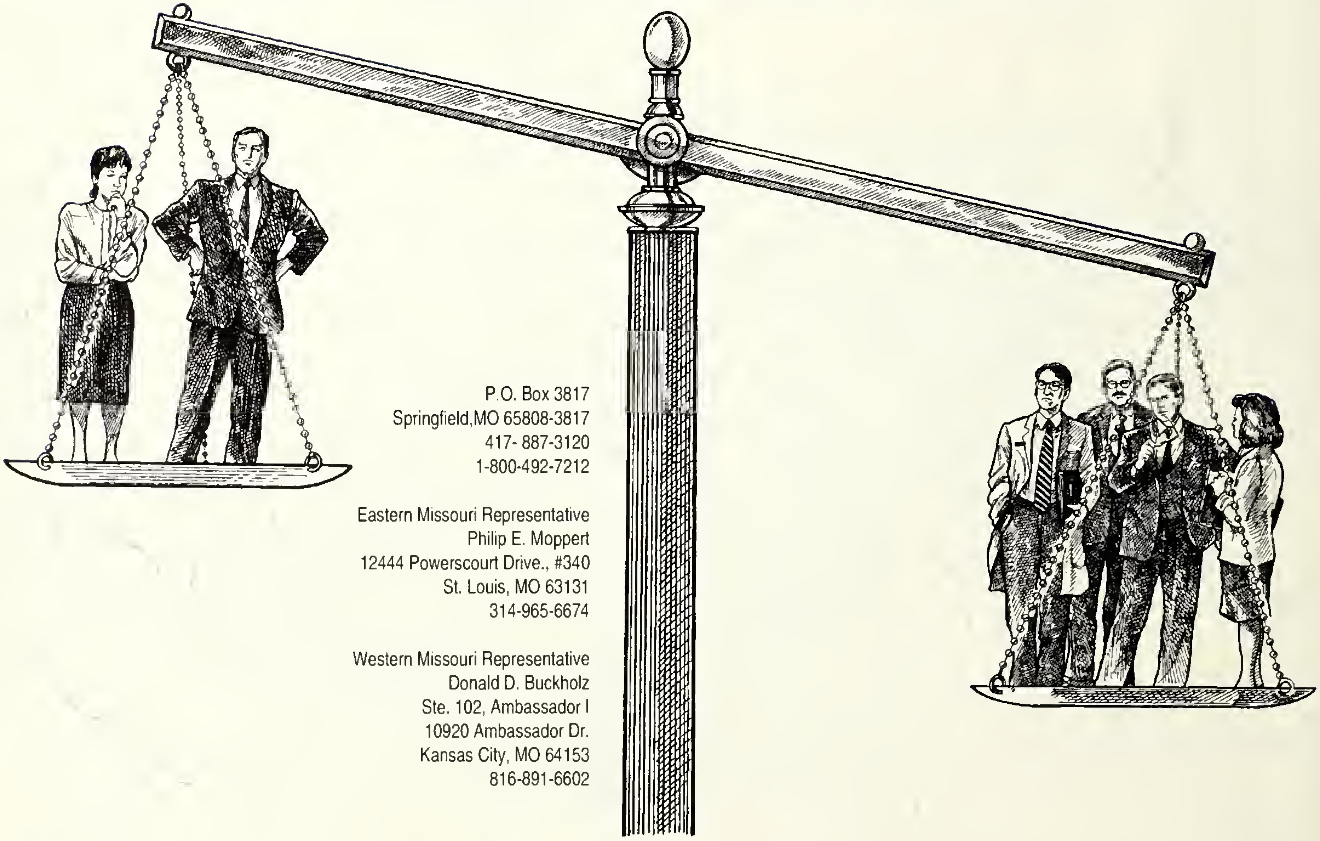

Missouri Medicine

Journal of the Missouri State Medical Association

November 1992

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON, MA
NOV 23 1992

In this Issue:

- ☐ *Transfusion Medicine in the 90s, Why It Has Changed and How*
- ☐ *Dissociation of Somatosensory & Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor*
- ☐ *Contemporary Management of Chronic Persistent Cough*
- ☐ *CHAMPUS Guidelines for Missouri Physicians*
- ☐ *New! Dermatology Quiz (See inside back cover)*

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Owned and edited since 1904 by the Missouri State Medical Association. *Missouri Medicine*, Journal of the Missouri State Medical Association, is published monthly at 113 Madison, Jefferson City, Missouri 65102 Second-Class postage paid at Jefferson City, Missouri and at additional mailing offices. Postmaster: Send address changes to Missouri State Medical Association, c/o Membership Dept. P.O. Box 1028, Jefferson City, MO 65102.

The subscription price per year for non-members is $20.00. Annual subscription for members is included in the annual membership dues. The international subscription price is $40.00. Single copies are $4.00 and the cost of a copy of the annual August Directory issue is $15.00.

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Printed by the Ovid Bell Press, Inc., Fulton, Missouri 65251.

CONTENTS

VOLUME 89, NUMBER 11

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON, MA
NOV 23 1992

MSMA Ombudsman's Update

CHAMPUS Guidelines for Missouri Physicians
Patrick J. Mills, CPA, M.B.A. 782

Perspectives

The Wall
Donald G. Sessions, M.D., Contributing Editor 779

Humor Is Good Medicine, Volume 2
John C. Hagan, III, M.D. 781

Editor's Desk

Hugh E. Stephenson, Jr., M.D.
J. Regan Thomas, M.D., Editor 771

Scientific Articles

Transfusion Medicine in the '90s, Why It Has Changed and How
David L. Pittman, M.D. and Michael R. Phillips, B.A. 785

Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor
Siavash S. Haghighi, D.V.M., Ph.D., Donald H. York, Ph.D., John Ebeling, M.D., Mary K. Gumerlock, M.D., John J. Oro, M.D., and Robert W. Gaines, M.D. 790

Contemporary Management of Chronic Persistent Cough
Mir F. Shuttari, M.D. and Sheldon R. Braun, M.D. 795

Departments

MSMA Officers, Councilors and Delegates 769
Letters to the Editor 777
Auxiliary Message 773
Physician Recognition Awards 803
Disciplinary Actions 805
Practice Management 775
New Members 806
In Memoriam 809
Medical School and Member News 754
CME Calendar 812
Classified Advertisements 814
Information for Contributors 817
Dermatology Quiz 801, 819

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Journal of the Missouri State Medical Association

Vol. 89, No. 11 November 1992

"Election Day" is a 16" X 24" oil painting by Jesse Barnes. Born in Jefferson City in 1936, he currently resides in Springfield, Missouri. He is a self-taught artist, with a professional career of nearly 30 years. His first limited edition print was released December, 1983. Jesse Barnes, "The Light Painter," is known for his expressive lighting effects in paintings that take the viewer back to the past. Another trademark of his work is the inclusion of an owl in every painting.

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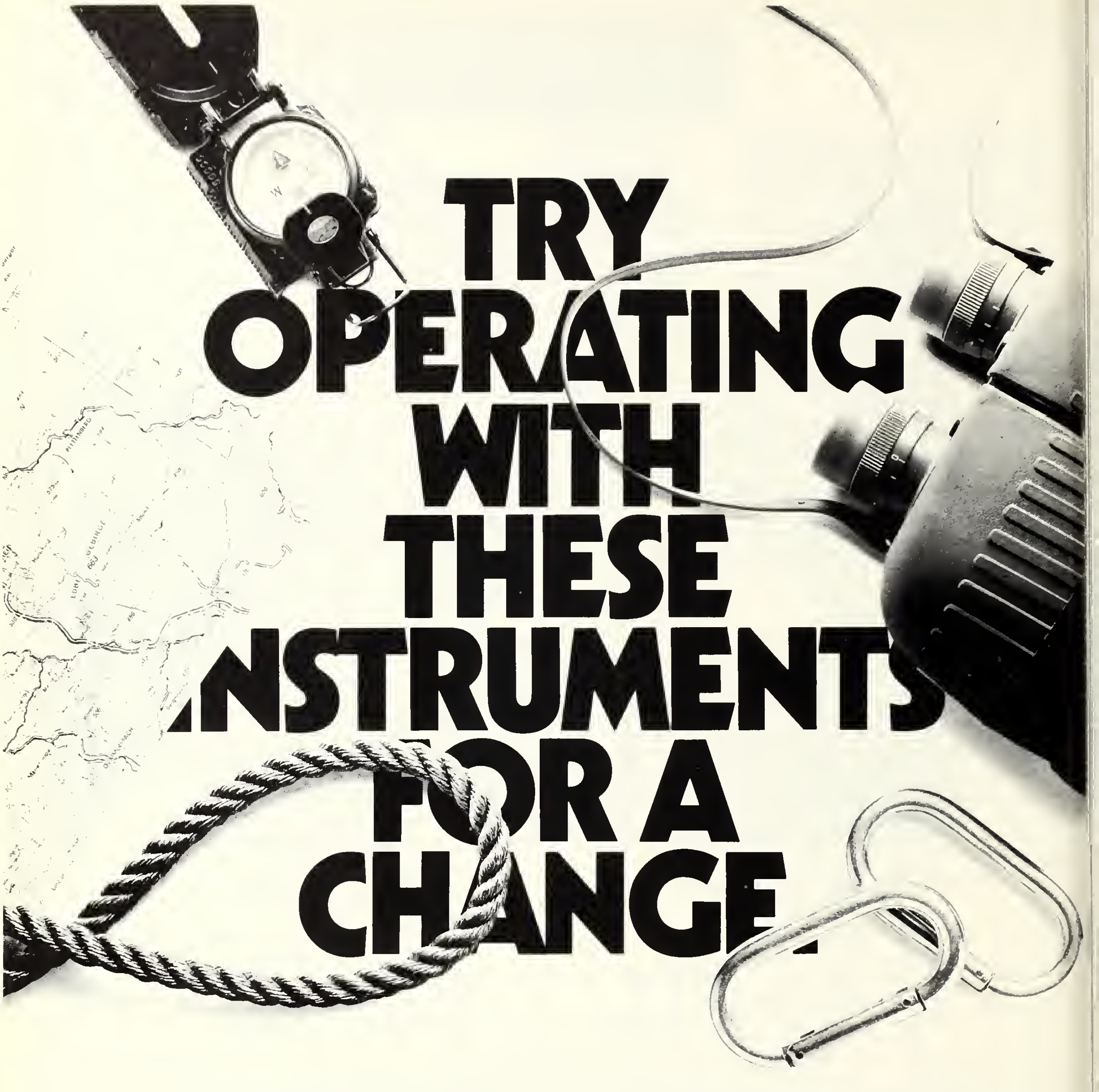

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Hugh E. Stephenson Jr., M.D.

by J. Regan Thomas, M.D., Editor

Hugh Stephenson Jr., M.D.

Those of us who have the privilege of knowing Hugh Stephenson Jr., M.D., realize he is not really retiring. In spite of the receptions, testimonials and presentations in his honor, we know it doesn't really mean retirement in the usual sense. It takes more than administrative or procedural regulations based on mere age to slow a lifetime of achievement. Especially for an individual who seems to genuinely love his work. More importantly, he has that special ability to inspire a love for that "work" in others. That's a unique inertial force that is nearly impossible to stop.

It is difficult to pay tribute to the accomplishments of Hugh's life and career. The problem of course is a matter of space. He has a career which provides a C.V. with more pages than this entire journal. And where would one begin? Maybe by noting that he was valedictorian at Hickman High School in Columbia, Missouri, or perhaps by remembering him as the University's first Markle Scholar, or as a founder of Alpha Omega Alpha Honorary at the University. For that matter, he is generally credited as being instrumental in gaining approval for the medical school to be a full four-year program. Incidently, Hugh was the first full-time faculty member of that fledgling institution.

He was recognized early in his career by the U.S. Jaycees when he was named one of the Ten Outstanding Young Men of the Nation in 1956. In 1962 he was the first person from the U.S. to be named Surgical Traveler for the James IV Association of Surgeons to the United Kingdom. Please note at this point, these are only highlights of his honors and accomplishments until that time. I still have thirty more years of career to talk about to bring you up to date.

Through those next thirty years, honors and accolades continued to accumulate. Hugh characteristically has accepted this recognition with quiet humility and self-effacing humor. He is the recipient of the Distinguished Faculty Award from the University of Missouri, the Citation of Merit Award from the University of Missouri Alumni Association, and the Washington University Medical Alumni Association's Alumni Achievement Award.

Certified by the American Board of Surgery and Board of Thoracic Surgery, Hugh has been recognized both for the importance of his surgical endeavors as well as his impact on medical education. His scholarly activities include over 135 scientific articles and several textbooks.

Hugh's leadership roles have been just as impressive with involvement in local, state and national organizations. He has been president of the Missouri Chapter of the American Association of University Professors, state president of the American College of Chest Physicians, president of the Boone County Medical Society, the Missouri Chapter of the American College of Surgeons, Missouri State Surgical Society and UMC Medical School Foundation. He has served as chairman of the Missouri delegation to the AMA and was elected to the prestigious Council on Medical Education by the AMA House of Delegates.

The University of Missouri School of Medicine has benefited enormously from Hugh's energy and leadership. He has served in many capacities including chairman of the Surgery Department, chief of General Surgery Service. He was the first elected chief of staff and served as interim dean of the medical school. He was named the John Growder Distin-

Continued on page 772

Continued from page 771

guished Professor of Surgery and Associate Dean for Clinical Development.

In spite of all the honors, accomplishments and leadership roles in medicine, (and by the way I didn't list them all!), Hugh is not a one-dimensional person. He has been a dedicated family man. Hugh and his wife Sally have two very talented children, Ann and Ted. He likewise has a number of non-medical interests including football. As the author of the definitive book on drop-kicking in football, *The Kicks That Count*, he has acted as kicking consultant to both college and professional football teams. You have to take a guy seriously who has a set of goal posts in his yard!

When Hugh was named 1990 Doctor of the Year by the Boone County Medical Society, his "home" society, said of him, "Thank you, Dr. Stephenson, for being who and what you are." Hugh was quoted in the local newspaper as saying, "One's reputation among one's colleagues is more valuable than anything money can buy." By that standard, Hugh is a wealthy man.

He has been called "Dr. Mizzou" in one newspaper and dubbed "Mr. Medicine" in another. In an editorial, a newspaper writer said , "Hugh Stephenson is one of those people whose travel through life makes a difference."

Paula Seymour provided the description of Hugh Stephenson which is the closest to my feelings about him. Paula is now a mother of two and living in Peculiar, Missouri. But in 1958 she was a sickly seven year old who became the first person to undergo open-heart surgery at the University of Missouri Medical Center in Columbia. In a recent interview she remembered her surgeon, Dr. Stephenson, who performed this first procedure. Still handsome and dapper, Hugh was remembered as a dashing figure to the young patient. "I thought he was extremely good-looking," Paula recalled.

She remembered also the key to all of our memories about Hugh. "He was so gentle and understanding. I've never seen another doctor treat me the way he did."

All of us who have contact with Hugh feel that way about him.

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FAMILY VIOLENCE

How you can help decrease family violence and victimization within your community

by Ruth Kiekhaefer, MSMA Auxiliary Health Promotion Vice President

One night several years ago while working the ER at our local hospital my husband, Ted, was called to see a patient with scalp lacerations. The patient, a man, had two parallel 7.5 cm lacerations at the mid-portion of the scalp. The lacerations were about 2.5 cm apart. As Ted treated the scalp injuries, he was curious as to what would cause such an injury. When he asked the patient, the reply was "My wife and I had an argument and she hit me over the head with an iron skillet. I blinked and told her that it felt good. Do it again, and, by God, she did." This patient and his wife were regulars in the ER. The husband weighed about 110 lbs and his wife about 310 lbs. That night the man went home with a friend and would not talk to his wife. The couple was referred to a social service agency and to marriage counseling.

Two nights later they returned to the ER bringing in one of their children to be seen. The couple was holding hands. Because the couple chose to ignore the advice to receive counseling, the destructive behavior continued, and they were seen again and again in the ER.

In the ensuing years my husband sutured other lacerations that were inflicted on this man by his wife. The police were called to their home to settle domestic disputes also.

The End of a Sad Tale.

Domestic violence touches 25% of all American families. The percentage of couples who will experience violence at sometime during their marriage is increasing. Odds are that either the husband or wife will beat the other partner at some point in their relationship. Approximately 900,000 parents are beaten or abused by their children. More than one million older Americans are physically or emotionally abused by their relatives. Child homicide is now among the five leading causes of death in childhood. Court referrals of abused children doubled in Missouri in the past ten years. As you peruse these facts, **please consider solutions**.

Medical auxiliaries across the state will be promoting programs that educate people about violence. The *Shaken Baby Syndrome* brochure will be distributed to as many obstetric units as possible with the goal being that a brochure will accompany each baby home. This brochure could also be placed in any clinic or office. Programs on family violence will also be addressed.

Doctor, would you consider what impact you could have on these problems? The problems will not go away without our help. Here are some plans of action that you can take **now**:

1. Put *Shaken Baby Syndrome* brochures in your waiting room.
2. Volunteer to speak on violence to your favorite group.
3. Offer your suggestions to your local Auxiliary president.

To get **free** materials to help you implement your plan of action write to:

Marie Williams, Executive Secretary
Missouri Chapter,
National Committee for
Prevention of Child Abuse
P.O. Box 531
Jefferson City, MO 65102
or call 314/751-5253

For Family Violence brochures:
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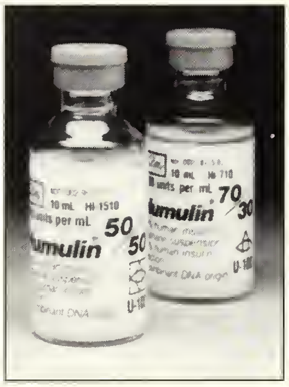

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Dear Dr. Woerth,

The payments that Medicare is allowing for services I render is so low that I find my revenues have declined considerably. Have you any suggestions of how physicians in my situation can improve revenues?

Dr. T.S.

Dear Dr. T.S.,

The medical practice that is to survive and thrive in today's medical community is going to have to take a good, long look at every means possible to generate revenues. It's no longer enough to trim the fat from the office overhead and run the most efficient office possible. In the 1990s, it's going to take new sources of revenue to keep the financial status of a practice healthy.

In the 70s and 80s physicians started investing in labs, home health agencies, and other medical related businesses as sources of revenue. Current Federal legislation, the Stark law, is rendering these businesses uncertain, if not illegal, revenue sources. So what's left? Personnel!

In the past, personnel have been considered an office expense. With the new Medicare fee schedule reform came good news about reimbursement for non-physician health care providers. Medicare is paying the physician assistant (PA) 85% of the physician fee schedule for treating patients in settings other than the hospital, i.e. medical offices and nursing homes. Medicare reimbursement for services rendered by the PA in the hospital setting is 75% of what the physician is reimbursed. In rural settings, clinical nurse specialists (CNS) and nurse practitioners (NP) are also paid 85% of the physician fee schedule in non-hospital settings and 75% of the physician fee schedule (including assistant-at-surgery services) in the hospital settings.

Beside the PA, CNS, and the NP, Medicare is also reimbursing for other non-physician providers. Medicare will reimburse physical and occupational therapists for services they render at the same rate it reimburses a physician for the same services. Medicare also reimburses at 100% of the physician fee schedule for the diagnostic test furnished by clinical psychologists and clinical social workers. Thus it might be financially beneficial for these non-physician providers to be included as full or part-time employees in some practices.

As Congress looks at various methods to reduce Medicare expenditures, it is likely that other non-physician providers, like nurses, may be considered for reimbursement of services they render to Medicare patients. Until that time, the efficient medical practice should be delegating medical procedures to those non-physician providers that are reimbursed by Medicare.

Dear Dr. Woerth,

I just received a letter from Medicare asking for copies of medical records for three of my patients each having two visits. Medicare did not say why they wanted this information. Do you have any idea why Medicare would want this information?

Dr. M.J.

Dear Dr. M.J.,

Congress has appropriated funds to the Health Care Financial Administration (HCFA), which is responsible for Medicare, to review physicians' medical records to determine how they are using the new evaluation and management codes. Your name was selected at random for this E and M (evaluation and management) review. Although it is an "audit" of sorts, the findings do not result in punitive action against or rewards for the physician whose records are reviewed. The audit is solely for the purpose of gathering information as to how physicians are using the evaluation and management codes. You might be interested to know that for those whose Medicare carrier is General American, in approximately 33% of the records reviewed, the physician does not provide enough documentation to justify the level of evaluation and management he/she has selected.

Do you have a question for Dr. Woerth? Include your questions along with your name, address and phone number and send them to:

Janice K. Woerth, Ph.D.
Practice Management
c/o *Missouri Medicine*
P.O. Box 1028
Jefferson City, MO 65102
Or call her direct:
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Although your name will not be used in *Missouri Medicine*, please include your name and phone number so that Dr. Woerth may contact you if she needs additional information to answer your question.

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Dear Editor,

MSMA recently has received statistics for Missouri offices and clinics of medical doctors, SIC code #8011 from the OSHA regional office in K.C.. From January 1, 1991 through September 1, 1992 two inspections were conducted. One had no violations and the other was cited for four violations - three of these related to hazard communication. The fourth was for not posting the OSHA poster. The total fine was $50.

There were 99 such inspections of doctors' offices in the U.S. for the same time period. These inspections had adjusted penalties of about $120,000. This averages to two inspections for each state with adjusted penalties of $1,200 for each. OSHA will often adjust initial penalties for small employers, less than 25 employees, and when a good faith effort is made to correct the violation quickly. However, future violations will be more costly, initial penalties have been increased in 1992 by a factor of seven.

The most frequently violated standards are:

1. Hazard Communication
2. Posting the OSHA poster
3. Posting the OSHA 200 log
4. Blood Borne Pathogen

OSHA is not targeting physicians' offices for inspection. The primary reason for all inspections is employee complaints. If any MSMA member has questions about OSHA, they may contact me at the MSMA office in Jefferson City.

Sincerely,
Patrick J. Mills, CPA, MBA
MSMA Ombudsman

Dear Editor,

For the past several years, we have experienced a rather rapid tuition and fees increase here at the MU School of Medicine. Unfortunately, low interest federal loans have not been able to keep up with this climb.

We want you to know that it was the Missouri State Medical Foundation loans this year that were a lifesaver for many of our students. We went from 37 students borrowing $132,780 in 1991-1992 to 82 students borrowing $312,000 this year.

Thank you for this service to our students. We especially want you to know that Wilma Sperry, the Assistant Secretary handling the loan operation, has done an outstanding job in meeting this increase in demand and getting the checks to the students earlier than ever before. We appreciate her conscientiousness, efficiency and courtesy.

Again, thank you for this program and its efficient operation.

Sincerely,
Ted Groshong, M.D.
Associate Dean for Medical Education

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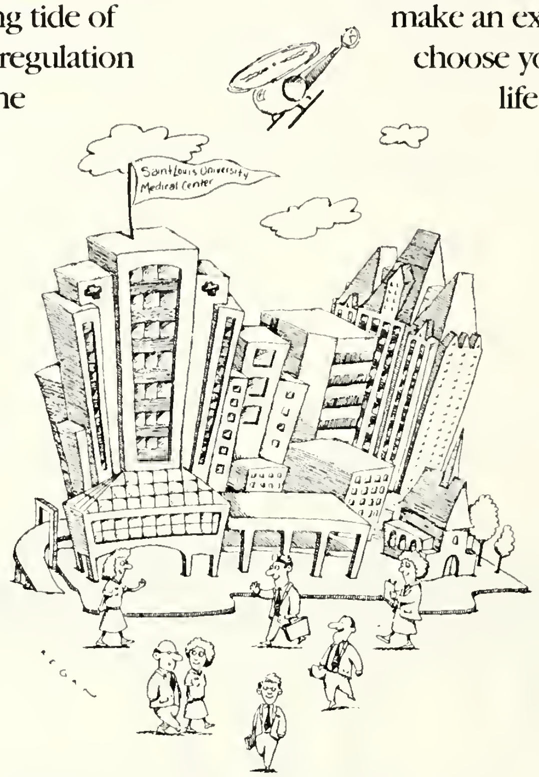
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THE WALL

by Donald G. Sessions, M.D.

Washington D.C., I am standing on the steps of the Capitol looking west, down the Mall towards the Potomac River. I am attending a medical meeting and have taken off early today, in the middle of the afternoon. I'm on a quest. I'm going to visit the Vietnam War Memorial. I remember having seen it on another visit but from afar. This time I'm going to see it up close.

I walk down the steps. The sun is beginning to go down so as I walk west I am looking almost directly into it. The afternoon is quite warm and it is just beginning to cool down. The Mall has a large central grassy area and is rimmed on both sides by wide gravel paths. I walk on the north side. At regular intervals there are wooden benches on concrete bases. Today, most of the benches are filled with tourists pouring over maps. They are young and many appear to be speaking foreign languages. To my right behind the benches is an area of thick grass under medium sized leafy trees. Small groups of people sit on the ground in the shade. There are individual joggers and an occasional bicyclist. There are no poor people panhandling for money today. There is a sense of peace and tranquility.

At regular intervals the Mall is intersected by cross streets. Traffic is minimal until I get to the Washington Monument. Hesitantly I ask a well-dressed couple directions to The Wall. They know what I am asking but they don't have the slightest idea where it is. I find a map which shows me where it is. I'm only about half way there. It's way west near the north edge of the Mall. I pass a beautiful pond, go over a small rise and finally see the sign. It requests us to stay on the path, not to skate, and not to jog.

I walk over some flagstones down to The Wall. There are actually two walls, made of highly polished black marble, that meet each other at a comfortable angle. The Wall literally is covered with names. I am suddenly aware of the quietness. There is a feeling that I am not alone, which has nothing to do with the fact that there aren't many visitors. I have experienced this phenomenon once before - in the Canyon de Chelly on the Navajo Indian Reservation in northeastern Arizona. The experience is one of awe and wonder coupled with a sense of connection with those who are not present and yet somehow are.

I walk up to The Wall. Each name represents someone who once had the same dreams that I had. We were of the same generation. I am overwhelmed. Although I served in the Air Force during the war I have never confused my activity with that of those who were in combat. Heat radiates from the black marble. I reach out and touch it. It is hot and smooth.

I see that the names are not in alphabetical order. I am looking for a name. I realize I will never find it without help. I ask a national park ranger how to find a name on The Wall. He opens a worn paperback book, finds the name, and takes me to it. On the way I side step some paper flowers and a faded polaroid picture at the base of The Wall. There is the name, up at the top on the right hand side, about a third of the way out from the middle - Gilbert O. Ruff Jr. He was the husband of my secretary. I never knew him. She said that he had entered the service with a clear sense of duty and honor and the optimism of youth. "My number came up and I'm going... I can take care of myself," he said. He was killed near the village of Thua Thien near the Thailand border. He was twenty-four years old.

The ranger turns to go and I ask him if I can get a rubbing of the name for his widow. He says he'll be glad to do it. He says, "We use this soft graphite. At night, after hours, you'd be surprised what people use, ballpoint pens and the like, that scratch the marble." He gets a ladder, climbs slowly to the top, and carefully takes a rubbing. I steady the tippy ladder. Tears fall on my cheeks. Gilbert O Ruff Jr. - I didn't know him but I am him. In mourning him and the others I honor what is good in myself. The ranger hands me the rubbing. I send him back up to the ladder to rub the "Jr." which he has omitted. Amazingly, he treats this request almost as a privilege.

The Wall as a memorial is an extraordinary experience. I wonder what we have learned from the war. Experiencing memorials has a way of triggering these thoughts. Can we get along with others, especially those who are different than us? Was it worth it? What can we do to make it worth it? These are my thoughts as I walk back up the Mall to my hotel.

That night about ten o'clock two of my otolaryngology resident-physicians are riding rented bicycles along the northern gravel pathway on the Mall. As they near the level of the Natural History Museum

Continued on page 780

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Continued from page 779

they hear what sounds like Indian war hoops. Fifteen D.C. teenagers suddenly attack from out of the darkness under the trees to the north. One resident reacts quickly, riding powerfully to safety. "I'm from Texas," he says later, "and when I hear war hoops and see that I'm outnumbered, I take off." The other resident is knocked off his bicycle to the ground where he is hit and kicked viciously. He reaches for his wallet. As he says, "Here, take my money," he is hit savagely on the back of the head. Fearing for his life he breaks through the attackers sprinting to the nearest street where he flags down a passing police car. On returning to the scene, the attackers and the bicycle are permanently missing. Both residents are shocked by the surprise and the suddenness of the attack. Both feel fortunate. They'll think twice before bicycling on the Mall at night.

I am left pondering the questions - What have we learned from the war? Can we get along with others, especially if they are different than us? Was it worth it? What can we do to make it worth it?

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Humor is Good Medicine, Volume 2

by John C. Hagan III, M.D.

This second dose of medical humor, like last month's, comes to us from an ophthalmologist. Ophthalmologists reportedly have taken the largest Medicare and RBRVS reimbursement cutbacks. If they can still retain a sense of humor then the rest of our readers should take heart.

1. **Cosmetic Surgeon's Coda**:
Beauty is only skin deep. Ugly goes clear to the bone.

2. **First Law of Medical Statistics**:
If the statistics don't support your opinion, you obviously need more statistics.

3. **Second Law of Medical Statistics:**
Given enough statistics, you can prove anything.

4. **O'Toole's Corollary to Murphy's Laws:**
Murphy was an optimist.

5. **Surgical Scheduling Basics.**
   - A. The first 90% of an operation takes 90% of the scheduled time; the last 10% of the operation takes the other 90% of the scheduled time.
   - B. Every operation takes longer than it takes.
   - C. All surgeons believe a loud, shrill, angry voice insures getting elective cases scheduled immediately as emergency cases.
   - D. All surgeons believe a loud, shrill, angry voice will prevent emergency cases from "bumping" their elective cases.
   - E. All surgeons believe all their scheduled cases are emergencies.

6. **Palmer's Theorem:**
The three principle functions of the human spine are: 1) to support the head, 2) to support the ribs, 3) to support the chiropractor.

7. **The Law of all Laws:**
Mother Nature is a bitch.

8. **Hagan's Observations:**
   - A. Your most complicated and time consuming case of the week will always be your last scheduled office patient on Friday afternoon.
   - B. Your most complicated and time consuming case of the year will always be your last scheduled office patient the day you plan to leave on the year's biggest vacation.
   - C. Letting someone in the operating room say "Gee, things are really going smoothly today" or "We're going to get our cases done early today" practically guarantees a complication.
   - D. It is impossible to get through a local anesthesia case without someone on the surgical team saying "Oops".

9. **The George Armstrong Custer Principle:**
Optimism indicates that the situation has not been clearly understood.

10. **Medical Dictionary Terms:**

Artery	Study of paintings
Bacteria	Back door to a cafeteria
Bowel	Letters like A, E, I, O, U
Cataract	Rich person's car
Caesarian Section	District in ancient Rome
CAT Scan	Search for a kitty
Cauterize	Made eye contact with her
Coma	Punctuation mark
D & C	Where Washington is
Congenital	Friendly
Condom	Death sentence
Genital	Non-Jewish
Hang Nail	Coat Hook
Impotent	Distinguished, well-known
Labor Pain	Hurt at work
Morbid	Higher offer
Nasal	End of a hose
Nephrotic	Overly anxious
Olfactory	Aging infrastructure
Post-Op	Letter Carrier
Recovery Room	Place to upholster
Rheumatic	Amorous
Secretion	Hiding something
Semen	Ship's crew
Tablet	Small table
Terminal Illness	Getting sick at the airport
Tibia	Country in Africa
Tumor	More than one
Urine	Opposite of "you're out"
Vein	Conceited

CHAMPUS Guidelines for Missouri Physicians

by Patrick J. Mills, CPA, M.B.A.

CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services. Starting May 1, 1992, the Texas Medical Foundation (TMF) began reviewing inpatient services provided to CHAMPUS beneficiaries in acute care civilian hospitals and rehabilitation units, including hospitals participating in coordinated care and children's hospitals in Missouri, Texas, Oklahoma, Kansas, Arkansas, and Louisiana.

Missouri physicians who treat CHAMPUS patients will receive faster response from the office in Austin, Texas, says Phil Dunne, TMF's executive director, if correct information is provided while filing claims and when requesting preadmission/ preprocedure authorizations.

Dunne suggests that physicians keep on hand the correct phone numbers to call for information and review; the information that must be provided to TMF; a list of the diagnoses and procedures that require prior authorization; and the timing of the review request.

The telephone numbers of several offices that Missouri physicians can call for information and a list of procedures that require preadmission or preprocedure authorization are shown below and on the following page.

TMF office: 901 Mopac Expressway South, Suite 200, Austin, Texas 78746. For a treatment authorization number: 800/299-3627 and for general information: 800/299-8963.

Wisconsin Physician Services (the CHAMPUS carrier): File claims at WPS, PO Box 7939, Madison, WI 53708-7939. For general information, other than authorization information, call: 800/388-6767. In Missouri and Kansas, the WPS representative is Dennis Martin, PO Box 204, Grandview, MO 64030 or call 816/761-7112.

Physicians should request a treatment authorization number prior to admission, before a procedure, or within two working days of an emergency admission or procedure. Preadmission or preprocedure authorizations may be obtained up to 30 days in advance, and treatment numbers assigned by TMF remain valid for 30 days from the date the original admission or procedure was scheduled. TMF should be notified if the hospital, surgical setting, or physician changes. If the admission or procedure is not performed within 30 days, TMF must reauthorize the procedure or admission.

Claims for work done outside the 30-day window without notification to TMF, or if done without a treatment authorization number, will be paid, but the case will automatically be selected for retrospective review of the medical record. When calling for authorization, the physician or staff member should be prepared to provide the following information.

The beneficiary's full name, CHAMPUS identification number, age, and date of birth; date of admission or procedure; hospital name and provider number; physician's name, UPIN, and telephone number; and pertinent medical information that substantiates the beneficiary's medical need for the admission or procedure.

In peer review, the records are sent to peer physicians whose practices best match the conditions of the case, i.e. rural cases by rural physicians, urban by urban doctors, and so forth to determine the medical necessity and appropriateness of the setting for inpatient admissions for selected principal diagnoses and for selected procedures (see list), regardless of whether the procedure is principal or secondary.

TMF is a non-profit, private, offshoot of the Texas State Medical Association. It was chartered as a separate entity in 1972 and began providing CHAMPUS services to Texas residents in 1988. Physicians in Missouri are not targeted to receive TMF publications and news, but rather should look to the MSMA's ombudsman/ communication program or local hospital administrators for updated information about CHAMPUS.

CHAMPUS Diagnoses and Procedures which require preadmission/preprocedure authorization

Simple Pneumonia

485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
487.0	Influenza with pneumonia

Bronchitis/Asthma

466.0	Acute bronchitis
466.1	Acute bronchiolitis
490	Bronchitis, not specified as acute or chronic
491.0	Simple chronic bronchitis
491.9	Unspecified chronic bronchitis
493.00	Extrinsic asthma w/o status asthmaticus
493.10	Intrinsic asthma w/o status asthmaticus
493.90	Asthma, unspecified w/o status asthmaticus
493.01	Intrinsic asthma w/ status asthmaticus
493.11	Intrinsic asthma w/ status asthmaticus
493.91	Asthma, unspecified w/status asthmaticus

Coronary Artery Bypass Graft

36.10	Aortocoronary bypass for heart revascularization, not otherwise specified.
36.11	Aortocoronary bypass of one coronary artery
36.12	Aortocoronary bypass of two coronary arteries
36.13	Aortocoronary bypass of three coronary arteries
36.14	Aortocoronary bypass of four or more coronary arteries
36.15	Single internal mammary-coronary artery bypass
36.16	Double internal mammary-coronary artery bypass
36.19	Other bypass anastomosis for heart revascularization

Angioplasty/Endarterectomy

36.01	Coronary (balloon) (single vessel)
36.02	With thrombolytic agent infusion
36.05	Multiple vessels
38.12	Endarterectomy - head and neck

Cardiac Catheterization

37.21	Right heart cardiac catheterization
37.22	Left heart cardiac catheterization
37.23	Combined right and left cardiac catheterization
88.55	Coronary arteriography - single catheter
88.56	Coronary arteriography - two catheter
88.57	Other and unspecified arteriography

Gastritis/Dehydration

276.5	Dehydration
535.00	Acute gastritis w/o hemorrhage
535.30	Alcoholic gastritis w/o hemorrhage
535.50	Unspecified gastritis and duodenitis w/o hemorrhage
552.3	Diaphragmatic hernia with obstruction
553.3	Diaphragmatic hernia
558.9	Other and unspecified noninfectious gastroenteritis and colitis

Abortion

Two ICD-9-CM codes must be provided, one for the diagnosis and one for the procedure. Both codes must appear on the list of codes which require prior authorization; if not, the case does not require preprocedure review. The diagnosis code may be primary or secondary.

ICD-9-CM Diagnosis Codes

635.0x - .9x	Legally induced abortion
636.0x - .9x	Illegally induced abortion
637.0x - .9x	Unspecified abortion
638.0x - .9x	Failed attempted abortion
V61.7	Other unwanted pregnancy

ICM-9-CM Procedure Codes

69.01	Dilation and curettage for termination of pregnancy
69.02	Dilation and curettage following delivery or abortion
69.51	Aspiration curettage of uterus for termination of pregnancy
69.52	Aspiration curettage following delivery or abortion
74.91	Hysterotomy to terminate pregnancy

Note: CHAMPUS coverage for abortions is prohibited by law except where the life of the mother would be endangered if the fetus were carried to term.

Biliary Tract Operation

51.22	Total cholecystectomy
51.23	Laparoscopic cholecystectomy

C-Section/Removal of Fetus

74.0	Classical cesarean section
74.1	Low cervical cesarean section
74.2	Extraperitoneal cesarean section
74.4	Cesarean section of other specified type
74.99	Other cesarean section of unspecified type

Other Uterine Incision or Excision

68.4	Total abdominal hysterectomy
68.5	Vaginal hysterectomy

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Transfusion Medicine in the 1990s, Why It Has Changed and How

By David L. Pittman, M.D. and Michael R. Phillips, B.A.

This paper is intended for physicians not directly responsible for transfusion medicine in their everyday practices. The field has changed dramatically in the last decade. This paper attempts to outline these changes, and detail factors that will be of practical use in general, medical, and surgical practices. Topics include available blood products with indications and risks, education about types of blood donation, possible future products, and a key concept in the field today, "conservation."

During medical training, physicians were exposed to a plethora of subjects. Some topics received numerous hours of lecture or hands-on training such as basic sciences, pharmacology, physical examination, procedures, and so on, while other topics such as transfusion medicine received little emphasis. In this article, we try to bring this topic into better focus.

WHY IT HAS CHANGED

Transfusion medicine has changed for many reasons, including perceived or real infectious disease risks, risks of allergic reactions, more stringent accreditation guidelines, dynamic donor supply, liability issues, and technological advances. However, nothing approaches the impact of Acquired Immunodeficiency Syndrome (AIDS). Public awareness of this disease has been magnified, and this has led to testing for other infectious diseases, some common -- as hepatitis C, and some quite rare -- as HTLV 1/2. This increased testing has made blood safer, but it remains a biologic product with inherent risks..

Table 1 gives the estimated percentage of selected transfusion risks, including HIV 1 (AIDS virus).[1] Transfusion reactions are the most common, with the rather innocuous febrile reaction having the highest frequency, 0.5%-1% of red cell transfusions[2] and 20%-30% of platelet transfusions.[3] Febrile reactions are due to preformed antibody to WBCs, platelets, or plasma proteins.

Recent data suggest 15,000 cases of transfusion associated AIDS (TAA) will occur in the pre-1985 transfusion group, when testing of blood for HIV 1 was not performed.[4] Since that time, approximately 100 million transfusions of blood products have been performed, with only 14 documented TAA cases.[4] So the current measures seem to have markedly altered this small TAA portion of the "epidemic" that represents less than 3% of AIDS cases. These measures include public education, better screening of donors, confidential deferral of transfused units, HIV 1 testing, and surrogate testing of donated blood. However, estimating the number of TAA cases is quite difficult and probably underestimated because of the long incubation period of the virus, under-reporting of the illness, and the rather high mortality due to underlying disease in transfused patients (60% one year survival).[4] The estimated chance of receiving an HIV-positive unit is 1 in 40,000 to 1 in 250,000.[5]

HOW IT HAS CHANGED

Technological and medical advances have markedly altered the practice of transfusion medicine. We explore changes in the field by examining the blood banking industry, reviewing blood products and indications for their use, and briefly reviewing regulatory issues.[6] In the United States, 99% of donated blood is from **volunteer donors**. This is true for all standard products we use in the hospital, except for rare red cell types, special factor concentrates such as Factors VIII, IX, antithrombin III, and immune serum globulin. Volunteer donations are safer for the patient because individuals who accept payment for donation are occasionally at high risk for transmissible diseases.[7] Fourteen million units are donated annually by 8 million donors, although fewer than 10% of eligible persons donate. Fluid repletion occurs within 24 hours, and red blood cell repletion occurs within eight weeks in non-iron deficient donors. Blood accounts for a $1 billion annual expenditure in the U.S.[8]

TYPES OF DONORS

Three basic types of blood donors exist: homologous, autologous and directed. A **homologous donor** gives voluntarily for any patient. This blood is matched for the major compatible red cell antigens of ABO group and Rh type, but it is not prematched for the approxi-

Table I

A. Infectious Risks:	
Hepatitis* -	0.5-1%
HIV I (AIDS) -	1/40,000
HTLV I -	1/10,000 or less
CMV seroconversion -	7%
Others: Syphilis, Chagas' disease, EBV, Leishmania (rare except endemic areas).	
B. Transfusion Risks:	
Volume Overload -	1/10,000
Acute Hemolytic Transfusion reaction -	1/25,000
Delayed Hemolytic Transfusion reaction -	1/2,500
Fatal Tx reaction -	1/100,000
WBC or platelet alloimmunization -	10%
RBC alloimmunization -	1%
Nonspecific reactions -	1-5%

* see adenddum, page 788

mately 400 other red cell or HLA antigens, unless the patient's serum contains an "irregular antibody." In such a case, crossmatching allows the selection of red cells lacking antigens that would react with the patient's "irregular antibody," usually provoked by previous exposure to blood during transfusion or childbirth. If the red cell antigen is a high frequency antigen, exact identification of the antibody subtype is helpful, so blood negative for this can be obtained more quickly.

An **autologous donor** donates to reserve blood for his or her own use. Transfusion reactions due to alloantibody formation and transmission of infectious disease are not problems. Autologous blood is safer, but bad outcomes may result from improper handling of the blood (osmotic, thermal, or mechanical damage) before or during transfusion.

A **directed donor** donates blood at the request of the patient. These are NOT volunteer donors! In Columbia, Missouri, directed donor blood is less likely to transmit infectious disease, but directed donors are not recommended in general. Serving as a directed donor can make family and friends feel they are doing something for their ill loved one, and this may benefit the donor emotionally. Physicians should also recall that children serving as directed donors do not necessarily have compatible blood types, even if the husband and wife have the same ABO Rh type. This may be because of 1) irregular antibody of intended recipient, 2) infectious marker in donor, and 3) lack of paternity -- and the time of illness is a painful time to discover this.

BLOOD PRODUCTS

Transfusion medicine has responded to the transmission of infectious diseases by performing more **testing for transmissible disease**, and more importantly, **beginning transfusion conservation practices**. Before we examine conservation practices, we should understand the products available in the bloodbank and their characteristics, including therapeutic indications, safety, volume, number of donor exposures, and out-date time.[9,10]

Red blood cell products are used to increase oxygen carrying capacity. They are not for use in volume expansion, not as a vitamin or mineral, and not to treat asymptomatic anemias. Packed red cells are "always" the choice because the volume is 250 mL, average out-date is 42 days (depending on the anticoagulant used), rare units can be frozen for 10 years, and each unit is from one donor. Alternatively, whole blood is nearly never the choice and could best be spelled "hole blood," because it seldom contains what the physician desires. The volume is 500 mL, average out-date is only 21 days, Factors VIII and XIII survive only about one week, and platelets last no more than three days. In contrast, when whole blood is separated, the packed red cells out-date at an average of 42 days, fresh frozen plasma (FFP) one year, and platelets five days. In the 1990s, a single unit transfusion of red cells is acceptable, if indicated. More is not necessarily better.

Plasma products include FFP, cryoprecipitate (cryo), and plasma derivatives - Factor concentrates, immune globulin, albumin, and plasma protein fraction. Only FFP and cryo come from volunteer donors. The volume of FFP is 220 mL, it can be frozen for one year, and it contains 1 unit/ml of multiple factor activity. Use of FFP is indicated for coumadin reversal, liver disease, vitamin K deficiency, disseminated intravascular coagulation, and selected factor level replacement when concentrates are not available. It is not for volume or protein repletion and carries one donor exposure per unit.

Cryoprecipitate also has one donor exposure per unit, and is a concentrated source of fibrinogen, Von Willebrand factor, and Factors VIII and XIII. Pooling the units in multiples of five to 20 is necessary because of the small volume (15 mL per unit), which leads to the retention of too much in the tubing and bag when it is given in single units. In a nonbleeding 70 kg patient, 10 pooled cryo units will raise the fibrinogen level by about 100 mg/dL.

Factor concentrates are pooled from hundreds or even thousands of donors and carry a high risk of disease transmission. From our experience with patients with hemophilia A and AIDS, it makes no sense to use 60° C dry heat treated Factor VIII concentrate, especially in HIV-negative hemophiliacs. Newer, but more expensive concentrates are safer due to better purification using 80° C

Table 2

Procedure	Equip./Labor	Effort Pre/Postop	Risk	Units	Hospital Size
A-Autol Predon	1	3/1	1	1-4	S,M,L
B-Intraop Salv	3	1/3	2	1-4	L
C-Postop Salv	3	1/3	2	1-4	L
D-Hemodilute	2	2/2	2	1-3	S,M,L
E-Plt Rich Plas	3	3/2	2	??	L
G-Tx Trigger	1	1/1	1	1-3	S,M,L

Key: 1, 2, 3 = minimal, moderate, maximum, S, M, L,-= small, medium, large hospital

dry heat, liquid heat, solvent detergent treatment, or immunoaffinity purification.[11] These techniques markedly reduce the risk of HIV and hepatitis transmission. Factor IX concentrate purification has lagged, but some safer products are now available.

Immune globulin is quite safe due to the fractionation process, as are albumin and purified protein fraction (PPF). Albumin and PPF are used to increase plasma oncotic pressure via volume and protein repletion. Because of the extended heating period they undergo during preparation, they are said not to transmit viral infection and are safer than FFP. They do not contain clotting agents. Five percent albumin and PPF are osmotically and oncotically equivalent to plasma.

Platelet Concentrates have been improved by improved storage and cytapheresis collection techniques. Improvements in cytapheresis technology include a closed system and five day bags, giving us a better product more readily available. In the past, 90% of platelets were available as "donor platelets" that came from one unit of donated whole blood, to be pooled from six to ten donors for effective transfusion response.[12] Now, however, 30% or more of platelets are single donor cytapheresis packs, varying from five to eight single pack equivalents.[12] This is better for the patient who is likely to require long term platelet support -- i.e., due to cancer, aplastic anemia, myelodysplasia/myeloproliferative patients -- as there will be less chance of developing HLA antibodies which make them platelet refractory. Furthermore each cytapheresis pack gives only one donor exposure per transfusion episode. The best scenario for the post-transfusion platelet increment is usually 10,000/µL for each random donor platelet pack, and 60,000 for each cytapheresis pack, in a nonbleeding, nonrefractory 70 kg man.

WBC filters, irradiation to prevent graft versus host disease (GVHD), and HLA matched platelets are now common as well. Improved WBC filters, which can be used with platelets or red blood cells, remove 99% of the WBCs.[13] Use of the filters reduces febrile reactions, decreases HLA sensitization, and may decrease cytomegalovirus seroconversion and infection. In allogenic bone marrow transplantation, autologous bone marrow transplantation (ABMT), and first degree relatives of donors, the recommendation is to irradiate blood to decrease the potential of GVHD, with this complication common in the former and occasional to rare in the latter two categories.[14]

Table 3

Transfusion Trigger in CABG Patients

1. Red Blood Cells

Most normovolemic patients undergoing elective operation can tolerate Hgb to 8 or below, cardiac patients to 9 gm or below.

2. Platelets

A. Transfuse if clinical bleeding: for long pump time with platelet count less than 100,000, or others less than 80,000, or prolonged Bleeding Time with other normal coagulation studies.

B. Think 6 packs pooled random instead of 10 packs.

C. Use WBC removal filters in patients with likely longterm platelet transfusion requirements.

D. Use single donor cytapheresis platelets whenever available.

3. Fresh Frozen Plasma

A. Transfuse for unexplained bleeding, or markedly prolonged protime.

B. Give no more than 2 units until PT, PTT, fibrinogen, and platelet count return.

C. Make sure Heparin is reversed before FFP is given for elevated PTT.

4. Cryoprecipitate

Transfuse for bleeding in patients with fibrinogen less than 100 mg/dL, or if less than 150 following a rapid decrease of 200 mg/dL.

STEM CELL PRODUCTS

One of the bright spots in the near future for bloodbank products may be **autologous stem cell products**. Autologous bone marrow transplantation and peripheral blood stem cell transplantation (PBSCT) are currently used after high dose chemotherapy to allow marrow recovery. The current use of cytokines, such as erythropoietin for red cells and colony stimulating factors for granulocytes and macrophages, has made this even more effective and safe.[15] These techniques coupled with positive selection of stem cells[16] may create a concentrated product which is suitable for a high percentage of cancer patients who develop a prolonged pancytopenic state while on cycle chemotherapy. Such a product might become a standard bloodbank product collected early in the treatment of all cancer patients destined for chemotherapy.

CONSERVATION TECHNIQUES

The above advances have allowed conservation techniques to be widely applied. Several of these techniques are listed below and in Table 2. The effort required, risk, number units salvageable, and hospital size suited for the technique are also listed in Table 2.[17]

To understand transfusion conservation, one must understand the term "transfusion exposure." This can be defined as the number of allogenic donors to which the patient is exposed with each transfused product. For red blood cells, each unit has one donor exposure. Transfusion exposures for FFP, cryo, and random donor platelets are usually multiple. For single donor cytapheresis platelets there is one, and for autologous blood there is none.

Autologous predonation is the easiest form of conservation. It should be considered for any patient undergoing elective surgery with about a 50% risk of requiring blood. The patient can donate weekly as long as the Hct is 34% or more. Supplemental iron is given, and it is best if the patient can tolerate a 10%-15% drop in blood volume. As such, conditions such as aortic stenosis, unstable angina, recent MI, and COPD are relative contraindications, but not absolute, especially if isovolemic phlebotomy is employed. With this technique the blood volume is kept steady by infusing crystalloid or colloid agents in one arm, while phlebotomizing from the other.

A second and easily available method is to change the **transfusion trigger**. Physicians should learn the appropriate indications for transfusing each component. For example, it is inappropriate to transfuse every surgical patient to a standard Hgb, such as 10 gm/dL. There is good evidence that oxygenation and wound healing are adequate to well below 8 gm/dL. However, each case is unique. See Table 3, which shows a transfusion trigger for coronary artery bypass graft (CABG) patients at Boone Hospital Center (BHC). The trigger has been important in reducing transfusion exposure from 10.9 to below 5, during the entire hospital stay. What is your transfusion trigger, and should it be tightened?

At BHC, altering the transfusion trigger was coupled with greater use of **intraoperative salvage and selective postoperative salvage**. For clean cardiac cases, a cell salvage device with cell washing capability is used. Postoperative salvage of shed mediastinal blood has been less successful, as rare instances of severe pulmonary vascular reactions and hypo- or hypertensive episodes occur, probably due to reinfusion of vasoactive substances.[18] Alternatively, **postoperative salvage** in orthopedic cases using active drainage devices such as the Stryker or Solcotrans is useful, economical, and low-risk for salvage of one to two units over four to eight hours.

A less common form of conservation is **preoperative hemodilution**, where one to four units are drawn isovolemically from the patient to reduce the Hct to 35% or less. The blood is held in the operating room as autologous whole blood and returned to the patient when the procedure has ended, or within four hours. During the operation, the patient then bleeds at a lower Hct and loses less red cell mass.

Other conservation measures such as **platelet rich plasmapheresis** (Plt Rich Plas) and **artificial blood** are available but currently of limited benefit, and require greater expertise and risks.

ACCREDITATION AGENCIES

The accreditation required of blood collection centers has multiplied since the discovery of HIV 1, and has helped make blood safer, though such accreditation certainly has and will continue to increase costs. Has the pendulum swung far to one side, with stringent requirements impossible to attain? Blood is an inherently dangerous biologic product, yet it is increasingly being treated by the accreditation regulatory agencies as a chemical product that can be altered and made risk free. Risk-free transfusion seems unlikely, until safe artificial blood substitutes are developed.

CONCLUSION

This paper has attempted a swift overview of changes in transfusion medicine. This is a dynamic field, and not unlike Missouri weather, is likely to change.

* addendum

Since this manuscript was submitted for publication a recent article in the *New England Journal of Medicine* 1992;327:369-373, suggests the most common form of past transfusion hepatitis (hepatitis C) has been reduced to 0.03% by screening for antibodies for hepatitis C.

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Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor

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Mary K. Gumerlock, M.D., John J. Oro, M.D., and Robert W. Gaines, M.D.

We describe a patient with an intramedullary spinal tumor who demonstrated postoperative improvement of motor and sensory function despite the lack of somatosensory evoked potentials (SSEPs) before and after intraoperative monitoring. The motor system was evaluated by direct spinal cord stimulation across the tumor bed. The resultant evoked compound muscle action potentials and compound nerve activities were normal. Although there is sufficient clinical evidence that SSEPs are sensitive to posterior and posterolateral ischemic insults of the spinal cord, the technique should be employed with an awareness of its limitations in monitoring the descending tracts which have a different blood supply and occupy more anterior locations in the spinal cord.

The utility of somatosensory evoked potentials (SSEPs) monitoring techniques in the operating room has been established for some time.[1,2,3] The method allows effective monitoring of posterior columns and posterolateral pathways in the anesthetized patient.[4] The prognostic value of SSEPs in predicting recovery of motor function remains limited, however.[5,6,7] We describe a patient in whom no cortical SSEPs were present during operation on a spinal cord tumor, yet spinal cord stimulation proximal to the tumor site revealed preservation of motor function throughout the operation.

CASE REPORT

A 46-year-old man had a 16-year history of dull interscapular back pain associated with progressive decreased sensation and tingling in his feet and legs. One month prior to admission, he became increasingly clumsy and required a cane for walking. He also complained of urinary urgency.

Examination revealed a dull ache on spine palpation at the T2 level. The patient was alert and oriented with normal cranial nerve function. The arms showed a C8-T1 sensory level to light touch and pinprick bilaterally. Muscle strength testing revealed spastic upper motor neuron weakness 4/5 in an elective pattern below C8. The legs had no proprioception, nor sensation to vibration and light touch below the hips. He localized deep pain in his feet. Reflexes were 3+ in the arms and 4+ in the legs with sustained ankle clonus and Babinski signs bilaterally. The magnetic resonance imaging (MRI) and computerized tomographic studies with intrathecal contrast demonstrated an intrinsic spinal cord mass and associated cysts extending from C3 through T6 (Fig 1). While under evaluation the patient deteriorated to a non-ambulatory state.

After preoperative preparation with decadron (40 mg/day), the patient was taken to the operating room. Anesthesia was induced with diazepam, sufentanil, and pavulon and maintained with sufentanil. Nitrous oxide and halogenated gas anesthesia were not used. Intraoperative somatosensory evoked potential monitoring was established. A laminectomy was performed from the C4 to T4 vertebral levels. Under microscopic visualization, the dura was opened, and a midline myelotomy (C6-C8) allowed gross total resection of the tumor mass using an ultrasonic aspirator. Cysts were encountered at the proximal and distal ends of the tumor. Histopathologic evaluation revealed a low grade ependymoma.

Postoperatively, the patient's sensory level ascended to C5 bilaterally and became more prominent over the arms and chest. The motor function also decreased throughout. Over four weeks his neurological function improved. The patient was transferred to a spinal cord rehabilitation unit. After ten weeks, the patient could walk approximately 30 yards with the aid of Canadian crutches and knee braces. He was fully continent of bowel and bladder with a normal postvoiding urine residual. He related full resolution of the dull interscapular pain he had had preoperatively. The neurological examination performed at that time demonstrated bilateral intrinsic wasting in the hands, right greater than left, and elective weakness 4/5 below C6. Vibratory sensation was intact in the arms. Hypesthesia to pinprick and light touch was present bilaterally below the C5 dermatome. Vibratory sensation was absent to the hips. Proprioception was present but reduced bilaterally in the feet. The patient could localize light touch in the legs and feet. Pinprick sensation was absent in the right leg and present over the left anterior thigh and dorsal foot.

The MRI scan of the cervicothoracic spinal cord showed atrophy at the operative site C4 through T4 with decompressed cysts seen both proximal and distal to the cord atrophy. There was no evidence of residual tumor (Fig 2).

EVOKED POTENTIAL MONITORING

SSEPs were obtained by using 0.2 msec square wave electrical stimuli at a random repetition rate of 2.7 to 5.1 Hz delivered transcutaneously to the posterior tibial nerve (PTN) with the cathode 3 cm proximal to the anode. The stimulus intensity was adjusted to produce a twitch of the toes. The evoked activity was amplified and filtered (low and high cutoff filters were set at 10 Hz and 500 Hz, respectively); a few hundred responses were summed and then averaged. Each analysis time was 150 msec. Recording electrodes were standard EEG needles. Electrode resistance was maintained at less than 5,000 ohms. Responses were replicated at least twice, and all data were plotted separately. Recording electrodes were placed over the popliteal fossa, and the Cz was referenced to the forehead (Fz) electrode (International 10-20 system).

For spinal cord stimulation, a new custom-designed stimulating electrode was used. The stimulating electrode had two contact discs spaced 2 cm apart and was made of stainless steel discs and wires. An 8-foot jackbox leadwire connected the strip electrode to a constant voltage source. Needle electrodes were inserted in the biceps brachii (BB), and abductor pollicis brevis (APB) to record evoked compound muscle action potentials (CMAPs). Additional recording electrodes were placed adjacent to the PTN at the popliteal fossa for recording compound nerve action potentials (CNAPs). Recording filter bandpass was 30-3000 Hz. Total analysis time was 50 msec. Short duration (50 microsecond) single electrical pulses at 10 to 20 volts (max) were used for spinal cord stimulation. The strip electrode was placed epidurally over the anterolateral quadrant of the spinal cord proximal to the tumor site.

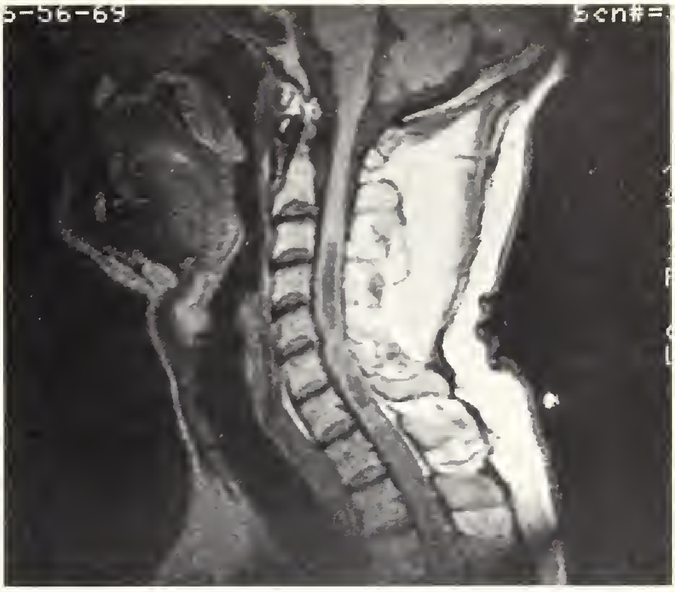

FIGURE 1: T-1 weighted image shows a widened spinal cord (arrowhead) from C3 to T1. Two separate cysts are also seen at the rostral (arrow) and caudal ends of the spinal cord mass.

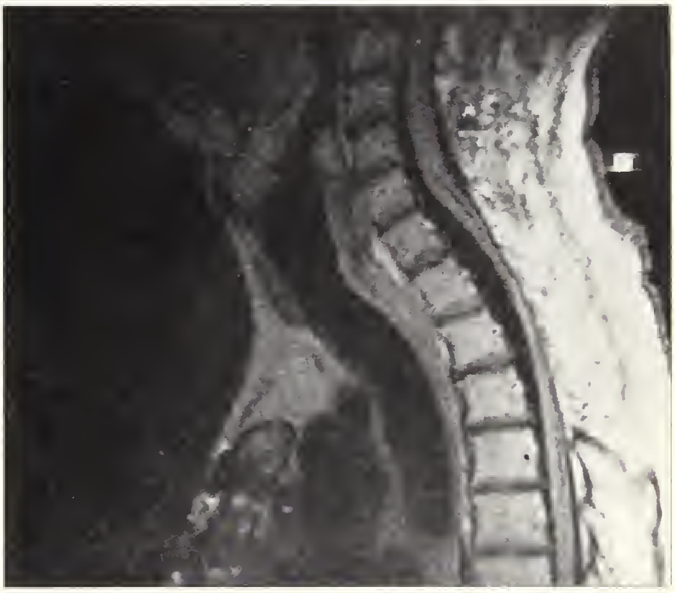

FIGURE 2: T-1 weighted image shows an atrophic spinal cord (arrowhead) from C6 to T3. Small collapsed cysts are also seen proximal (arrow) and distal to the atrophic area.

RESULTS

Intra-operatively, scalp SSEPs from Cz-Fz following the PTN stimulation were unobtainable (no reproducible waveforms associated with cortical responses), even with bilateral simultaneous stimulations of the PTNs. The CNAPs recorded from the popliteal fossa were normal with a clear N7 peak on each side (Fig 3). Inspection of the equipment and electrode impedance revealed no technical reason for the absence of cortical signals. There was no change in anesthetic level or the

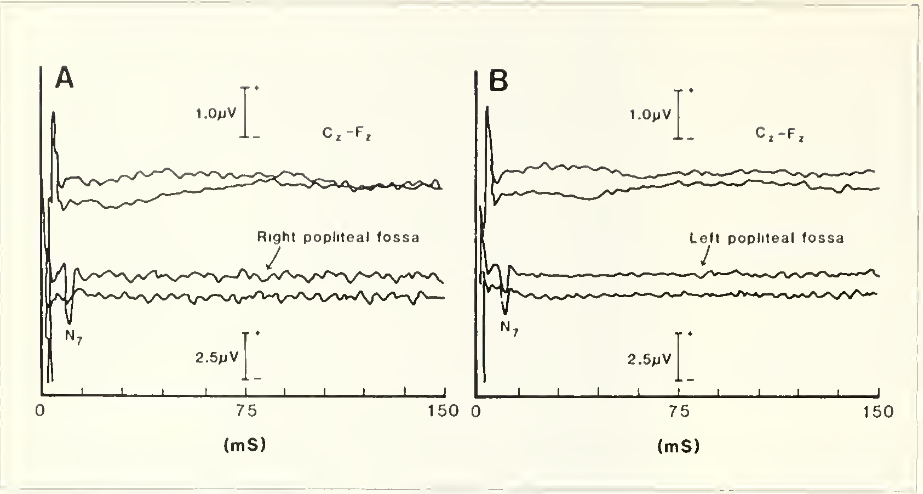

FIGURE 3: Cortical and popliteal evoked responses recorded after right (A) and left (B) posterior tibial nerve stimulation at the ankle. The presence of the N7 peak on both sides and the absence of any cortical responses suggests a loss of SSEP transmission through the spinal cord.

patient's vital signs throughout the recording. Epidural spinal stimulation of the left anterolateral C5 evoked CMAPs from the BB and the APB muscles bilaterally with higher amplitude responses on the left side (Fig 4). The descending CNAPs were also recorded from both PTNs after spinal cord stimulation (Fig 5). These potentials were lower in amplitude and required longer stimulation pulses (150-200 microseconds) for elicitation. Follow-up SSEPs at 10 weeks showed the presence of an N7 peak in the popliteal fossa bilaterally, again without a detectable cortical response.

DISCUSSION

The view that SSEPs may provide an effective monitor of not only the sensory pathways to the cerebral cortex, but also descending motor pathways has prevailed. However, our findings, together with those of other studies[4,8,9] do not support this view, but suggest that although vascular compromise of the spinal cord may affect both sensory and motor pathways, conclusions based on these findings must be placed in the context of relevant, specific pathophysiology in each case.

Previous longitudinal observation studies of spinal cord injured patients for several months after an injury have demonstrated that the SSEPs can remain within normal limits even though motor function of the lower limb is jeopardized.[4,8] Motor function may be altered with preservation of sensory function because the sensory tracts traverse the more posterior and posterolateral regions of the spinal cord with blood supply from the posterior spinal arteries, whereas the motor tracts are more medial and supplied by the anterior spinal artery. This has been demonstrated in a study of compression and localized spinal cord ischemia in the cat, in which a profound motor deficit was produced in the absence of any change in SSEPs.[10] Early studies involving the intraoperative use of SSEPs demonstrated that when significant changes in SSEPs were detected and a wake-up test was performed, motor impairment was observed.[11] The opposite scenario, with preservation of motor function after a decrement in SSEP amplitude, has also been observed, as has a loss of motor function in the face of unchanged SSEPs.[12,13,14] One interpretation of these results is that the SSEPs do not accurately predict compromise of motor pathways. This would be expected in situations involving a primary vascular condition affecting the blood supplies of the two pathways. The question of why the SSEPs would be affected at all by anterior spinal artery compromise may be explained by the possible role of the posterior spinocerebellar pathway in carrying the SSEP signal to the cortex.[7] Furthermore, since the posterior spinocerebellar tract may receive blood supply from both the posterior spinal and the anterior spinal arteries, it would be affected when motor tracts are compromised by decreased anterior spinal artery flow or perfusion.

However, in cases with no vascular compromise to the cord, but compression of the posterior columns, one would predict the SSEPs to be primarily affected without loss of motor tract function. In one case involving a myelotomy and retraction of the posterior columns, a loss of SSEPs correlated with the loss of joint position and vibratory sense in the lower limbs, but intact motor function.[5] Our case is similar in that SSEPs were never observed in response to stimulation in the lower limbs while motor evoked potentials remained intact.

This patient had a history of progressive reduction in sensation in the lower limbs, including proprioception, vibration and tactile sensation, with a motor and sensory level at C8-T1. The absence of SSEPs with PTN stimulation is consistent with loss of these sensory modalities and is similar to the postoperative findings of Chatrian et al.[5] Our case describes an intramedullary tumor and associated cysts, which caused progressive compromise of the posterior and posterolateral portion of the spinal cord. One would predict the resultant deficits in lower limb proprioception and vibratory sense (posterior spinocerebellar tract), fine touch (fasciculus gracilis) and some motor insult due to compression of the lateral corticospinal tracts. The compromise of motor function was not as severe as the sensory loss and this corresponds to the observed peripheral nerve CNAPs and the evoked electromyographic responses with spinal cord stimulation.

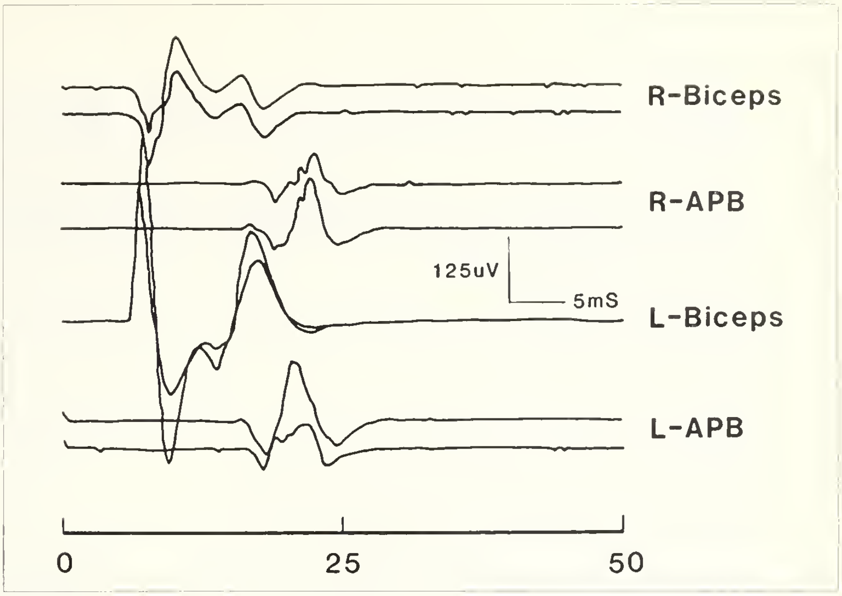

FIGURE 4: The evoked compound muscle action potentials of biceps brachii (BB) and abductor pollicis brevis (APB) muscles are obtained after single electrical stimulation of the spinal cord at C5.

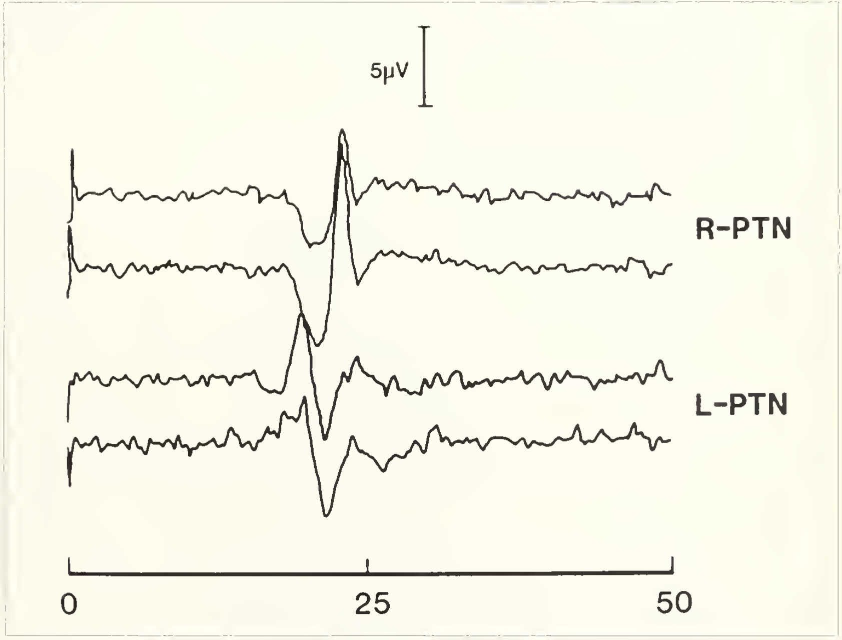

FIGURE 5: Single electrical stimulation of the spinal cord at T5 evoked compound nerve action potentials recorded from the posterior tibial nerves (PTN).

The paradoxical recovery of lower limb proprioception and light touch sensation after 10 weeks, without return of SSEPs, is also similar to the postoperative findings of Chatrian et al.[5] In an earlier study, where posterior columns were surgically severed in eight patients, no permanent loss of vibration or position sense was found.[15] Also, Netsky,[16] in a clinicopathological study of syringomyelia, found six patients who had a loss of vibration sense correlated with cavitation in the medial portion of the lateral funiculi. These two studies would suggest that the recovery of sensory modalities in our patient are due to recovery of function in the posterior spinocerebellar tract, which may have received only a transient insult from the spinal mass. This would also imply that the posterior spinocerebellar tract plays a larger functional role and only a minor role in SSEP conduction. The continued absence of lower limb SSEPs would be consistent with a significant residual deficit in transmission through fasciculus gracilis.

While not yet routine, intraoperative spinal cord stimulation will likely become a common method of evaluating the descending tract. Machida et al[9] have also used standard intra-operative SSEPs coupled with spinal cord stimulation and peripheral compound action potential recording. They too suggest that SSEPs represent signals carried in both the dorsal columns and the spinocerebellar tract, with the scalp P31 recording representing primarily the posterior columns. Following spinal cord stimulation, tibial nerve action potentials of approximately five microvolts with a latency of approximately 20 msec were recorded; values similar to those in our patient (Fig 5). Muscle action potentials in the study by Machida et al[9] varied in amplitude, as they did in our study, possibly a consequence of electrode placement.

In summary, our case illustrates a clinical correlation between the findings on neurologic examination, the operative pathology, and the results of SSEP and MEP monitoring. This in turn serves to corroborate the theories regarding function of the posterior columns and posterior spinocerebellar tracts. The discrepancy between ascending SSEPs and descending spinal cord evoked MEPs emphasizes the inherent difficulty in relying on SSEPs to predict motor system compromise. Finally, intraoperative epidural ventral spinal cord stimulation is a feasible adjunct to SSEP monitoring which may provide a more accurately predictive assessment of full spinal cord function.

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Contemporary Management of Chronic Persistent Cough

Mir F. Shuttari, M.D., and Sheldon R. Braun, M.D.

A chronic persistent cough is one that lasts longer than eight weeks in a patient without known chronic pulmonary disease. These patients may experience prolonged frustration, guilt and self-imposed social isolation, besides risking the medical and surgical complications of recurrent coughing episodes, if the cause of their cough is not quickly established and treated. A comprehensive discussion of the management approach to this problem with reference to the recent literature is presented.

CASE REPORT

A 52-year-old, white, nonsmoking housewife developed a dry, hacking cough four years prior to her presentation to the pulmonary clinic. She denied any history of prior asthma, hemoptysis, weight loss or heartburn. She described her cough as occurring most of the day, every day, and apparently worse at night, interfering significantly with her sleep. An extensive investigation had been done before her arrival at our institution by several different physicians (an allergist, ENT physician, and pulmonologist). Their evaluations included several chest radiographs, sinus radiographs, sputum examination, PPD skin test and bronchoscopy, which all proved nondiagnostic. The patient had tried several antitussive agents, both prescription and nonprescription, without any lasting benefit.

She had been avoiding social activities because she was embarrassed by her repeated bouts of coughing. In her search for help for her problem, she had traveled to physicians in many different cities prior to her arrival at our clinic. At that time, she was not taking any medications except an over-the-counter cough syrup at night.

Physical examination, including a thorough otolaryngological examination, was unremarkable, except for the observation that the cough episodes became worse in the recumbent position.

The results of CXR, CBC and pulmonary function tests (PFTs), done on her first visit, were within normal range.

DISCUSSION

Cough is the most common symptom of respiratory disorders, but not all coughing problems are caused by problems in the respiratory system. Most patients and physicians are rarely alarmed by the mere presence of a cough unless it is associated with hemoptysis, high fever, or an abnormal chest radiograph. The majority of cough episodes are self-limited and probably secondary to a viral upper respiratory infection causing a transit bronchial and hyper-reactive state.[1]

There is, however, a group of patients[2,3] who make a total of 30 million annual office visits to primary care doctors, who have coughs that persist beyond the usual 6- to 8-week period attributable to a viral upper respiratory infection. The incidence of chronic persistent cough in the patients visiting pulmonary outpatient departments is estimated to be 10%,[4] and chronic cough is the fifth most common symptom of patients presenting to primary care doctors.[2]

Chronic persistent cough becomes a problem and a source of frustration for the patient and physician alike. These patients are usually fairly healthy otherwise, gainfully employed and socially active. Their persistent day- and nighttime episodes of coughing unresponsive to any of the highly advertised over-the-counter cough remedies, create a significant psychosocial problem for them besides making them susceptible to the medical and surgical complications of the repeated bouts of coughing (Table 1).

The task of finding the underlying cause of chronic persistent cough and treating the problem is not always easy for the physician, as the customary history and physical examination and chest radiographs often fail to lead towards a definite diagnosis. Several studies have been published in the last decade addressing the problem of diagnosing and treating chronic persistent cough.[4,5,6]

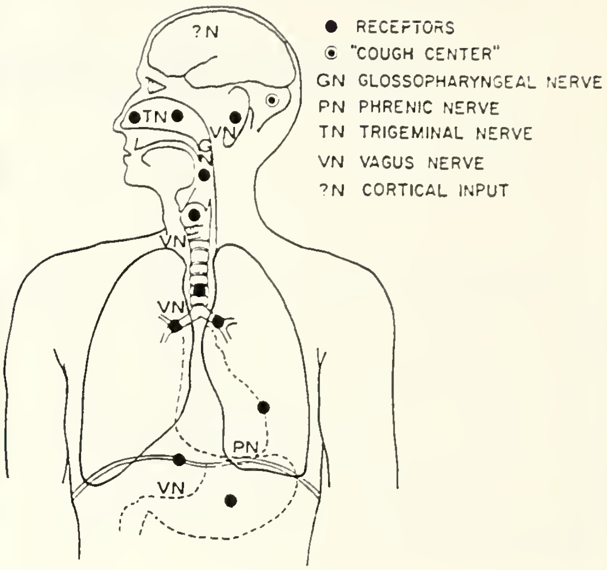
In order to apply the findings of these clinical studies to the patients physicians might encounter in clinical practice, it is important to ensure that a given

Table I

Complications of Chronic Cough

Musculoskeletal	1. Asymptomatic elevation of CPK 2. Rectus Abdominous muscle rupture 3. Rib fractures
Pulmonary	1. Pneumomediastinum 2. Pneumothorax
Cardiovascular	1. Loss of conciousness from reduced cardiac output during a bout of coughing 2. Bradycardia from elevated vagaltone
CNS	1. Cough syncope
Disturbed Sleep	Daytime somnolence, HTN, lack of concentrative ability at work.
Others	Urinary stress, incontinence, abdominal hernias, dehiscence of surgical wounds.

FIGURE I



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patient meets the inclusion criteria used by the investigators in their studies.

Chronic persistent cough is defined[5] as one that lasts for more than eight weeks. The patient should not have a known chronic lung disease at the time of onset of the cough, should not have a history of hemoptysis, and the chest radiograph done at the time of presentation should not contribute toward establishing a cause for the cough. The definition itself will help exclude the diagnosis of certain disease entities associated with chronic cough and abnormal chest radiographs, including pulmonary tuberculosis, bronchogenic cancer, and sarcoidosis[7] (Table 3)

Irwin[8] highlighted the concept of systematic evaluation of the different components of the cough reflex, emphasizing the different sites of cough receptors located not only in the respiratory system but also at several non-pulmonary sites (Fig 1).

THE COUGH REFLEX

Cough is triggered by stimulation (inflammatory, mechanical, thermal, chemical or neoplastic) at any receptor site for the reflex. Cough receptors are located not only in airways and lung parenchyma but also in several non-pulmonary sites, such as the tympanic membranes, the esophagus and pericardium. The afferent impulses travel to the cough centers in the medulla via different nerves -- vagus, trigeminal, glossopharyngeal and phrenic -- as determined by the site of stimulation. Efferent cough impulses travel from the cough center to effector organs, the glottis and expiratory muscles, via the vagus, phrenic and spinal nerves. These impulses result in a sequence of deep inspirations, immediately followed by glottic closure, active contraction of expiratory muscles, airway narrowing, glottic opening and explosive release of trapped air in the airways at high velocity. This results in removal of undesired material from the respiratory tract.

ANATOMIC DIAGNOSTIC PROTOCOL

When the stimulus at any one or more cough receptor sites is persistent and not effectively altered by the cough itself, the groundwork for chronic persistent cough is laid. The knowledge of the location of the cough receptors and the pathways involved in cough reflex has enabled investigators to plan a systematic diagnostic approach to solving the problem of chronic persistent cough. This approach is called the "anatomic diagnostic protocol."

In this diagnostic approach, clinicians try to gather information, either directly or indirectly, regarding the

Table 2

Major Causes of Chronic Persistent Cough with Normal Chest X-ray

1. Post Nasal Drip	41%
2. Bronchial Asthma	24%
3. Gastroesophageal Reflux	21%
4. Chronis bronchitis	5%
5. Bronchiectasis	4%

Irwin, R.S., A.R.R.D. 1990, 141 (3).

Table 3

Causes of Chronic Persistent Cough with Abnormal Chest X-ray

1. Bronchogenic Cancer	37%
2. Tuberculosis	16%
3. Pulmonary sarcoidosis	16%
4. Allergic alveolitis	9%

Puokjoki, H., Annals of Medicine 12/89, 21(6):425-427.

state of cough receptors. This entails investigating known receptor sites to try to identify a triggering stimulus. A thorough ENT examination evaluates cough receptor triggers in the upper airway, lung auscultation and PFTs plus methacholine inhalation challenge evaluates any bronchospastic disorder. If no diagnosis is established, a search for triggers of cough receptors in the esophagus -- gastroesophageal reflux (GER) for example -- is initiated.[9]

Two prospective studies by Irwin et al, published in 1981 and 1990,[4,6] used this approach to study causes for chronic persistent cough in adult patients referred to the pulmonary outpatient clinic. The studies involved 49 and 102 patients and provide useful information for the management of these patients. The anatomic diagnostic protocol used to evaluate these patients involved history and physical examination with emphasis on a thorough ENT examination, CXR, PFT, methacholine inhalation challenge (if resting PFT results are normal) and 24-hour esophageal pH monitoring (in the latter study). This approach resulted in the establishment of a cause in 100% and 99% of cases in the two studies. Based on the specific causes found, the treatment of chronic persistent cough was shown to be successful in 98% of cases with a specific diagnosis. Cough was found to be from a single cause in 73% of the cases; two different causes were found for 23% of the chronic persistent coughs, and three different causes were found in 3% of the cases studied. A study[5] published in 1989 seemed to have a slightly lower yield (88%) in terms of establishing the etiology for chronic persistent cough, but gastroesophageal pH monitoring was not part of the protocol in this study.

ETIOLOGY OF CHRONIC PERSISTENT COUGH

Among the causes for chronic persistent cough, post nasal drip syndrome (PNDS) was shown to be the leading cause (Table 2), bronchial asthma was the second most common cause (accounting for 24%) and GER the third most common (21%).[6]

These studies also showed that cough was the sole presenting manifestation of asthma in 28% of the patients with asthma in the study. Cough also was the sole presenting manifestation of GER disease in 43% of the patients with a diagnosis of GER in this study. This indicates that patients with GER may not complain of heartburn, but have a chronic cough that may be the manifestation of their disease. Among the most useful means of arriving at a diagnosis in chronic persistent cough as shown by Irwin and his colleagues,[6] is the least costly of all the diagnostic tools at our disposal, namely the history and physical examination (Table 4).

Key questions to ask patients with chronic persistent cough include: (1) whether the patient has a frequent need to clear the throat, suggesting postnasal drip, (2) whether there is a history of asthma or wheezing spells, (3) whether the patient has a history of heartburn, or if the cough is triggered or worsened when the patient is in a recumbent posture or both, suggesting GER, (4) whether the patient is using an ACE inhibitor, e.g., captopril, enalapril, cilazopril, or lisinopril. Chronic cough is reported in up to 15% of patients using ACE inhibitor drugs.[10,11]

A physical examination should include a thorough ENT evaluation, looking for postnasal drip, sinusitis, wax, or a foreign body on the tympanic membrane. One should also check for wheezing or crackles on lung examination and evidence of congestive heart failure. Initial ancillary investigation should include a chest radiograph, PFTs and CBC. If nondiagnostic, these should be followed with a methacholine inhalation challenge.

If the history and physical examination suggest the presence of sinusitis, a sinus radiograph should be considered. Suspected cardiac problems warrant consideration of two-dimensional echocardiography and EKG.

Table 4

What Helps in Diagnosing a Cause for Chronic Cough

1. History	70%
2. Physical examination	49%
3. PFT's	24%
4. MIC	22%
5. Barium esophagography	21%
6. 24 hour esophageal pH monitoring	16%
7. Sinus x-rays	15%
8. Chest x-rays	7%
9. Bronchoscopy	4%

PFT's = pulmonary function tests
MIC = methacholine inhalation challenge

Richard S. Irwin.

Table 5

Bronchoscopy in Chronic Cough

1. Contributes to diagnosis in only 4% of cases (chest x-ray normal, no hemotysis).
2. Localized wheezing on auscultation with or without an abnormal chest x-ray should be evaluated by bronchoscopy.
3. Patients over 40 years of age with a strong cigarette smoking history and no other explanation for chronic cough should be bronchoscoped.
4. May be done if no diagnostic information is obtained after following the protocol shown here.

Table 6

Rare Causes of Chronic Cough

1. ACE inhibitor drug use (6-15% of pts using the drug)
2. Hair or other F.B., impacted cerumen, over tympanic membrane
3. Cholesteatoma
4. Immotile cilia syndrome
5. Bordetella pertussis infection
6. Interstitial lung disease
7. F.B. aspiration (more common in children)
8. Transtracheal O2 delivery catheter
9. Pulmonary hypertension
10. L.V. dysfunction without florid congestive heart failure
11. Temporal arteritis

The next group of tests to be considered are those aimed at uncovering GER. A barium swallow with fluoroscopy in the erect and recumbent posture could be a good screening test, followed by 24-hour esophageal pH monitoring if barium fluoroscopy for GER is non-diagnostic.

The anatomic approach described here should enable a physician to evaluate the chronic cough patient confidently and cost-effectively. Take for instance, the case presented at the beginning of this article. The approach to her problem would be the same as for any problem in medicine, i.e., obtaining history, doing a physical examination and then obtaining ancillary data based on the probability of ruling in or ruling out a disease process.

In the history, questions should seek to uncover not only the statistically most prevalent causes for chronic persistent cough -- namely PNDS, bronchial asthma and GER -- but also other less common causes for chronic cough, such as bronchiectasis, chronic bronchitis, smoking, ACE inhibitor drug use, F.B. aspiration and cardiac problems (Table 6).

Our patient's history was not clearly indicative of any of these causes except for the fact that the coughing episodes worsened when the patient was in a recumbent posture. This suggested GER, but could also indicate chronic bronchitis, bronchiectasis and cardiac problems. Physical examination (including a thorough ENT examination) failed to show any evidence of PNDS, i.e. no secretions seen in posterior pharynx, no cobblestone changes of posterior pharyngeal mucosa. No sinus tenderness or impacted wax in the ear canals was noted. No wheezes were heard on auscultation of the chest and there was no clinical evidence of congestive heart failure. Initial evaluation including a chest radiograph, CBC and PFTs gave results within normal limits (Table 7).

Among the three most common causes of chronic persistent cough (PNDS, bronchial asthma, and GER), only PNDS appeared unlikely at this point in her evaluation. A methacholine inhalation challenge would be the next test, based on the frequency with which asthma is a cause of chronic persistent cough, but because the GER was a higher probability in this patient, a barium swallow test and fluoroscopy appeared more likely to yield a diagnosis. The patient demonstrated coughing spells with the confirmed GER of barium on recumbent fluoroscopy. Gastroesophageal reflux was established as the cause of her persistent cough.

Had we not found GER on fluoroscopy, an evaluation by methacholine inhalation challenge would have been our next step. A negative methacholine test or no symptomatic improvement in four to six weeks with a trial of inhaled beta$_2$ agonist would have prompted us to complete the GER evaluation by obtaining a 24-hour esophageal pH monitoring.

The patient was advised to elevate the head of her bed 30 degrees. She began taking an H$_2$ antagonist. She was also instructed to eat her supper at least four hours prior to bedtime, abstain from alcoholic beverages, and avoid tight-fitting garments that might raise intra-abdominal pressure.

She reported total disappearance of cough in the fourth week of her therapy and was free of the cough at her most recent follow-up visit six months later.

Respiratory symptoms from GER may require surgical intervention if medical treatment fails. Review of a study of surgical treatment for GER disease revealed that patients with well-preserved esophageal motility seem to benefit most from surgery to correct GER.[12]

Nonspecific antitussives can be used temporarily once a systematic plan of evaluation is in progress. Psychiatric consultation for psychogenic cough[13,14] may be considered if a complete evaluation, as shown in the protocol, is nondiagnostic. Psychiatric interventions may help in less than 1% of the cases of chronic persistent cough. This subject is well reviewed in Bluger.[14] Such therapy may be considered in the subgroup of patients who can sleep through the night without coughing but have a persistent cough during the daytime. Bronchoscopy is helpful in establishing a diagnosis in only about 4% of the cases of chronic persistent cough (Table 5).

Table 7

DIAGNOSTIC PROTOCOL FOR CHRONIC PERSISTENT COUGH

(over 8 weeks cough, no known chronic pulmunary disease, no hemoptysis, CXR non diagnostic)

I. HX:
1. Frequent need for clearing throat?
2. Known x-ray/endoscopy proven sinusitis?
3. Asthma? wheezing spells?
4. Heartburn, cough worse at night or with recumbency?
5. ACE inhibitor drug use?
6. Any cardiac problems?

II. Physical:
1. Good ENT exam. Look for secretions from posterior nasopharynx, sinusitis, F.B. or wax in ear canals, nasal polyps.
2. Any wheezes or prolonged expiratory phase.
3. Any clinical evidence of CHF.

III. Initial Labs:
PFT's, CXR, PA/Lat
CBC
± sinus x-rays

IV. Methacholine Inhalation Challenge or Pre and Post Exercise PFT's or 4 week trial of Inhaled B2 angonists

V. -Barium swallow with recumbent fluoroscopy ± 24° esophageal pH monitoring

if nondiagnostic

VI.
1. Consider Bronchoscopy.
2. Empiric trial of antitussives from 2-3 months
3. Psychiatric referral or a trial of antidepressant meds for 2-3 months.

Note: Work-up may be stopped at any point from II thru VI if a diagnosis is found and appropriate treatment initiated.

MIC = Methacholine inhalation challenge
ACE inhibitors - Angiotension converting enzyme inhibitors
PFTs = pulmonary function tests

SUMMARY

Chronic persistent cough is treatable when a systematic anatomic diagnostic approach is taken to establish its cause.

Post nasal drip syndrome, bronchial asthma and gastroesophageal reflux disease are the three leading causes. In a few cases, there may be more than one cause. Treatment, when based on an established cause, is successful in almost 100% of cases.

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STOP!

Test your diagnostic skill by turning to the case report printed on the inside back cover. Make your diagnosis from the information printed on that page.

ANSWER TO DERMATOLOGY QUIZ

by Kent D. Walker, M.D.

The correct answer is:
b. venous stasis ulceration.

Venous stasis (VS) ulceration is the most common cause of leg ulcers. Stasis ulcers account for approximately 90% of all lower extremity ulcers, with arterial insufficiency ulcers and neuropathic ulcers comprising most of the remaining 10%. The remaining causes of leg ulcers are myriad, but are also extremely rare by comparison.[1]

The etiology of VS lies in the fact that nearly all patients have incompetent perforating veins, which leads to a transmission of high pressure from the deep to the superficial venous system of the leg. This condition is known as ambulatory venous hypertension. The result is a distension of the capillaries in the skin and subcutaneous tissue, pericapillary fibrin deposition, limited oxygen perfusion, tissue hypoxia and ulceration.[2] The condition that classically is thought to lead to VS is deep venous thrombosis (DVT). As this patient's case demonstrates, VS ulcer patients usually don't have a history of DVT, and are more likely to have a history of superficial thrombophlebitis, or even silent thrombosis.

The clinical presentation of this patient is entirely typical. VS patients usually are older, with a long history of intermittent ulceration. Procedures such as skin grafting, which was performed twice in this patient, are generally doomed to failure unless the incompetent perforating veins are ligated, or religious compliance with compressive hosiery is achieved. The pain experienced by these patients is generally dull, aching and is worse when the legs are dependent. If reasonably good local care is performed, VS ulcers rarely become infected. The diagnosis of VS disease should be considered for any ulcer below the knee. These ulcers usually involve the ankle, and commonly are found on the medial surface where the highest number of perforating veins are found. The ulcer bed contains granulation tissue which represents new blood vessel formation, and as such, may bleed slowly with minor trauma.

The main considerations for differential diagnosis of leg ulcers are arterial insufficiency ulcers and neuropathic ulcers found on the insensate feet of diabetic patients. These conditions can generally be ruled out by clinical measures. Arterial ulcers are extremely painful, the pain is worsened by elevation, and they are located on the toes and dorsum of the feet. Any ulcer patient with non-palpable dorsalis pedis and posterior tibial pulses should have a non-invasive vascular examination. Ischemic ulcer patients usually have a resting ankle pressure below 50mmHg.[2] Neuropathic ulceration is generally found in diabetic patients who have lost sensation on the sole of the foot. Minor trauma, such as stepping on a thumb tack will go unnoticed for days and lead to necrosis and infection. These ulcers are located at pressure points (head of the first and fifth metatarsal), are painless, deep and bleed briskly with minor trauma.

The key to therapy of VS ulceration is to promote venous return and subsequently decreases venous hypertension in the superficial venous system. The standard of care for over the past 100 years has been the "Unna's Boot" covered with an elastic wrap. The addition of occlusive dressings and improved compressive bandage has modernized Paul G. Unna's original bandage. The following description of a bandage is what is currently being applied to effectively treat VS ulcer patients at the University of Missouri-Dermatology division:

Dressing change protocol:

1. Gently clean the leg and ulcer with lukewarm tap water or saline. Soap residue is irritating to the skin and is toxic to healing tissue.

2. Apply a biological dressing to the wound. If a hydrocolloid dressing is used (DuoDerm) leave one inch margin around the wound.

3. Vaseline is then applied to the leg to control dryness and prevent dermatitis. If dermatitis is present, one may use hydrocortisone ointment in place of vaseline.

4. Zinc-oxide gauze (Dome paste) is now applied starting at the metatarsal heads and wrapping in an overlapping fashion to the infrapatellar notch. This is not wrapped tightly.

5. 4" Coban self-adherent wrap is applied in an overlapping fashion with moderate tension.

Continued on page 802

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Continued from page 801

6. It is important to insure arterial flow before applying this dressing. Doppler studies may be needed.

7. The bandage is removed when the exudate overwhelms the capacity of the dressing. Patients are strictly advised to monitor the color of their toes and to call if they notice any increase in pain. This is usually unexplainable, but may indicate ischemia.

8. The hydrocolloid environment is anaerobic. You should expect a large amount of foul drainage underneath this dressing. This does not indicate a clinically significant infection. Clean the leg well and then evaluate for erythema, swelling, warmth and pain. If infection is suspected, obtain cultures, start systemic antibiotics and delay dressing until the infection is cleared. We generally change the dressing weekly for the average patient, and biweekly if the drainage is large.

9. This dressing may be unwrapped or removed with bandage scissor. Extreme care is required here. A small amount of vaseline on the scissor and pulling up on the dressing may help.

10. Patients who do not respond in 2-3 months should be evaluated for contributing factors.

Dressing protocol fashioned after a lecture by Claude Burton, M.D., Duke University Medical Center

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III **Scott R. Barrett, Jr., M.D.,** *Chesterfield, MO*
Gross and repeated negligence, incompetency.
Violation: Section 334.100.2(4),(5) RSMo. Supp. 1987; Section 334.100.2(4)(h),(5),(13) RSMo. Supp. 1988; Section 334.100.2(4),(5) RSMo Supp. 1989, Section 334.100.2(4),(24) RSMo Supp. 1990 and Section 199.065 RSMo Supp. 1986
Board Action: Revocation. Effective 8/6/92

III **Horst G. Blume, M.D.,** *Sioux City, IA*
Action taken in another state.
Violation: Section 334.100.2(8),(13) RSMo Supp. 1990
Board Action: Five (5) years probation.
Effective 10/1/92

III **Stanley Dombek, M.D.,** *Midwest City, OK*
Action taken in another state.
Violation: Section 334.100.2(8) RSMo Supp. 1986
Board Action: Two (2) years probation. Effective 8/7/92

III **Thomas Dougherty, Jr., M.D.,** *Plattsburg, MO*
Personal Impairment.
Violation: Section 334.100.2(1),(5),(13),(14) RSMo Supp. 1986
Board Action: Two (2) years probation.
Effective 8/1/92

III **Sudhir Goel, M.D.,** *St. Louis, MO*
Unprofessional conduct.
Violatin: Section 334.100.2(3),(4)(g) RSMo Supp. 1990 and Section 334.031.1 Supp. RSMo 1986
Board Action: Reprimand. Effective 8/17/92

III **Richard Lagueruela, M.D.,** *St. Louis, MO*
Sexual misconduct with a patient.
Violation: Section 334.100.2(5) RSMo
Board Action: Revocation with no reapplication for seven (7) years. Effective 8/12/92. Application for stay was filed and not ruled upon by court.

III **Philip Leeds, M.D.,** *Johnston, IA*
Unlawful possession of a controlled substance.
Violation: Section 334.100.1(5), (10), (11) RSMo Supp. 1978
Board Action: One (1) year probation. Effective 7/6/92

III **Joseph W. Manley, M.D.,** *Mission, KS*
Terminated and/or requested to withdraw from several medical facilities, failure to fully and truthfully answer questions on the renewal application.
Violation: Section 334.100.2(3), (4)(n), (14) RSMo Supp. 1991 and Section 334.100.2(4)(n) RSMo Supp. 1990
Board Action: Application for license renewal denied.
Effective 6/4/92

III **Sergio Orellano, M.D.,** *Kansas City, MO*
Personal Impairment
Violation: Section 334.100.2(1),(4),(5),(13),(22) RSMo
Board Action: Seven (7) years probation. Effective 9/1/92

III **Rene Smith, D.O.,** *Warrensburg, MO*
Unprofessional conduct and misconduct.
Violation: Section 334.100.2(3),(5),(14) RSMo Supp. 1981, Section 334.100.2(5) RSMo Supp. 1984, Section 334.100.2(5) RSMo Supp. 1986, Section 334.100.2(4) RSMo Supp. 1987 and Section 334.100.2(8) RSMo, Supp. 1989
Board Action: Revocation with no reapplication for seven (7) years. Effective 8/18/92

III **Ricky Allen Smith, M.D.,** *Sikeston, MO*
Probation violation. Dr. Smith did not follow Board directives.
Violation: Section 334.100.2(4)(o) RSMo Supp. 1991
Board Action: Formal reprimand. Effective 8/11/92

III **Gary L. Turner, D.O.,** *St. Louis, MO*
Personal Impairment.
Violation: Section 334.100.2(4)(h),(13),(22) RSMo Supp. 1990
Board Action: Two (2) months suspension followed by five (5) years probation. Effective 7/23/92

NEW MEMBERS

❖ **Christopher R. Andrews, M.D.,** 1002 McIntosh Circle Dr., Suite 3, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Andrews received his medical degree at the University of Missouri-Columbia, in 1988. He completed his residency at Northwestern Memorial Hospital, Chicago, IL. Dr. Andrews specializes in neurology.

❖ **Jeffrey O. Anglen, M.D.,** Dept. of Surgery, Div. of Orthopedic Surgery, University of Missouri, One Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Anglen received his medical degree at Johns Hopkins School of Medicine, Baltimore, MD, in 1983. He completed his residency at John Hopkins Hospital and fellowship at Tampa General Hospital. Dr. Anglen specializes in orthopedic trauma.

❖ **Bonnie-Lee Birchansky, M.D.,** Heartland Hospital West, 801 Faraon St., St. Joseph, MO 64501, has become a member of the Buchanan County Medical Society. Dr. Birchansky received her medical degree at the University of Miami School of Medicine, Miami, FL, in 1986. She completed her residency at the University of Texas Southwest Medical Center, Dallas, TX. Dr. Birchansky specializes in child psychiatry.

❖ **Steven C. Eldenburg, D.O.,** 700 South Limit, Sedalia, MO 65301, has become a member of the Pettis County Medical Society. Dr. Eldenberg received his doctor of osteopathy at the University of Health Sciences, Kansas City, MO, in 1988. He completed his residency at the University of Louisville, Louisville, KY. Dr. Eldenberg specializes in family practice.

❖ **John M. Finley, M.D.,** 3315 McIntosh, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Finley received his medical degree at Indiana University, Indianapolis, IN, in 1969. He completed his residency at Indiana University Hospitals. Dr. Finely specializes in plastic surgery.

❖ **Joseph P. Goldberg, M.D.,** 10561 Barkley, Suite 506, Overland Park, KS, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Goldberg received his medical degree at Case Western Reserve University School of Medicine, Cleveland, OH, in 1965. He completed his residency at Babies Hospital, Columbia University / Presbyterian Medical Center, New York, NY. Dr. Goldberg specializes in pediatrics.

❖ **Cathanie W. Halberstadt, M.D.,** 930 Carondelet, #304, Kansas City, MO 64114, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Halberstadt received her medical degree at the University of Kansas, Kansas City, KS, in 1987. She completed her residency at St. Luke's Hospital, Kansas City, MO. Dr. Halberstadt specializes in obstetrics-gynecology.

❖ **Stephen J. Haudrich, M.D.,** P.O. Box 1140, Camdenton, MO 65020, has become a member of the Lake of the Ozarks Medical Society. Dr. Haudrich received his medical degree at the University of Missouri-Columbia, in 1989. He completed his residency at the University of Missouri-Columbia. Dr. Haudrich specializes in family practice.

❖ **James E. Hays, M.D.,** P.O. Box 2644, 2301 McClelland Blvd., Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Hays received his medical degree at Stanford University School of Medicine, Palo Alto, CA, in 1967. He completed his residency at Parkland Memorial Hospital, Stanford University. Dr. Hays specializes in internal medicine.

❖ **Paul M. James, M.D.,** 2316 E. Meyer Blvd., Kansas City, MO 64132, has become a member of the Missouri State Medical Association. Dr. James received his medical degree at Hahnemann University, Philadelphia, PA, in 1959. He completed his residency at Hahnemann University and Hospital. Dr. James specializes in vascular surgery.

❖ **David E. Jimenez, M.D.,** University Hospital & Clinics, One Hospital Drive, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Jimenez received his medical degree at Temple University School of Medicine, Philadelphia, PA, in 1985. He completed his residency at Temple University. Dr. Jimenez specializes in neurosurgery.

❖ **Kevin D. Komes, M.D.,** Brady Building, St. John's Rehabilitation, 2727 McClelland Blvd, Joplin, MO 64804, has become a member of the Jasper County Medial Society. Dr. Komes received his medical degree at the University of Texas, Galveston, TX in 1988. He completed his residency at the University of Missouri-Columbia. Dr. Komes specializes in physical medicine and rehabilitation.

❖ **Irving E. LaFrancis, M.D.,** 2727 McClelland Blvd., Suite #1, P.O. Box 2786, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. LaFrancis received his medical degree at the University of South Carolina School of Medicine, Columbia, SC, in 1987. He completed his residency at Danbury Hospital, Yale University, Danbury, CT, and fellowship at Brown University Hospitals in Providence, RI. Dr. LaFrancis specializes in oncology and hematology.

❖ **Noel W. Lawson, M.D.,** Dept. of Anesthesiology, N314, University of Missouri Medical Center, Columbia, MO 65212, has become a member of the Boone County Medical Society. Dr. Lawson received his medical degree at the University of Arkansas, Little Rock, AR, in 1965. He completed his residency at Baylor Medical Center, Houston, TX. Dr. Lawson specializes in anesthesiology.

❖ **Margaret E. Nichols, M.D.,** 2817 McClelland Blvd., Suite 108, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Nichols received her medical degree at the University of Chicago, Chicago, IL, in 1983. She completed her residency at the University of Chicago. Dr. Nichols specializes in neurosurgery.

❖ **R. Bradley Reeves, M.D.,** 1111 McIntosh Circle, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Reeves received his medical degree at the University of Arkansas School of Medicine, Little Rock, AR, in 1986. He completed his residency at Presbyterian Hospital, Oklahoma City, OK. Dr. Reeves specializes in orthopedic surgery and sports medicine.

❖ **Joel Y. Riley, M.D.,** 1034 S. Brentwood Blvd., St. Louis, MO 63117, has become a member of the Missouri State Medical Association. Dr. Riley received his medical degree at Meharry Medical College, Nashville, TN, in 1986. He completed his residency and fellowship at St. Mary's Hospital, St. Louis. Dr. Riley specializes in internal medicine.

❖ **Howard L. Smith, M.D.,** 10 N. Garth Ave., Columbia, MO, has become a member of the Boone County Medical Society. Dr. Smith received his medical degree at the University of Oklahoma, Oklahoma City, OK, in 1985. He completed his residency at the University of Missouri-Columbia. Dr. Smith specializes in neurosurgery.

❖ **Darrell Swank, M.D.,** 2700 McClelland Blvd., Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Swank received his medical degree at the University of North Dakota School of Medicine, Grand Forks, SD, in 1986. He completed his residency at the Mayo Graduate School of Medicine, Rochester, MN. Dr. Swank specializes in pathology.

❖ **John M. Veitch, M.D.,** 2700 McClelland, Suite 104, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Veitch received his medical degree at the University of Minnesota, Minneapolis, MN, in 1970. He completed his residency at the University of New Mexico, Albuquerque, NM. Dr. Veitch specializes in orthopedic surgery and hand surgery.

❖ **Frederick R. Wheeler II, D.O.,** 921 E. 34th Street, Joplin, MO 64804, has become a member of the Jasper County Medical Society. Dr. Wheeler received his doctor of osteopathy at the University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, in 1983. He completed his residency at the Naval Hospital, Portsmouth, VA. Dr. Wheeler specializes in pediatrics.

❖ **James C. Wright, D.O.,** 210 Hospital Drive, Suite 101, Perryville, MO 63775, has become a member of the Perry-Ste. Genevieve Medical Society. Dr. Wright received his doctor of osteopathy at Kirksville College of Osteopathy Medicine, Kirksville, MO, in 1989. He completed his residency at the University of Arkansas, Pine Bluff, AR. Dr. Wright specializes in family practice.

❖ **David G. Yahnke, M.D.,** 301 W. Liberty St., Farmington, MO 63640, has become a member of the Mineral Area Medical Society. Dr. Yahnke received his medical degree at Indiana University, Indianapolis, IN, in 1966. He completed his residency at Indiana University. Dr. Yahnke specializes in obstetrics-gynecology.

❖ **Rose J. Zwerenz, M.D.,** 7900 Lee Summit Rd., Kansas City, MO, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Zwerenz received her medical degree at the University of Missouri-Kansas City, in 1982. She completed her residency at Truman Medical Center East Hospital. Dr. Zwerenz specializes in family practice.

Residents

Linda G. Bick, M.D., *Internal Medicine/Pediatrics*
Julie Anne D. Stansfield, M.D., *Internal Medicine*

Students

University of Missouri-Kansas City
Jacqueline D. Combellick

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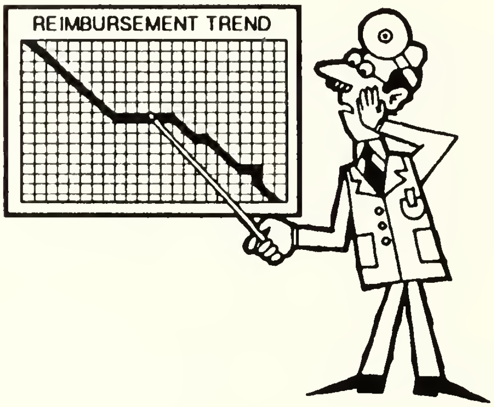

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■ **Christos Antoniou, M.D.,** St. Louis, Missouri, died August 31, 1992, at age 63. Dr. Antoniou received his medical degree at the University of Athens Medical School, Athens, Greece, in 1958. He joined St. Elizabeth's Medical Center in Granite City in 1986 and was chief of pediatrics for the past four years. Dr. Antoniou was on staff at St. John's Mercy Medical Center, St. Mary's Health Center, Missouri Baptist, St. Luke's, Jewish and St. Louis Children's Hospitals. He was also an instructor of pediatrics at Washington University Medical School. Dr. Antoniou was a diplomat of the American Board of Pediatrics and a member of the Missouri State Medical and American Medical Associations, American Academy of Pediatrics, and the St. Louis Pediatric Society.

■ **Leonard F. Fagan, M.D.,** St. Louis, Missouri, died September 15, 1992, at age 69. Dr. Fagan received his medical degree at St. Louis University School of Medicine in 1948. He was head of pediatric cardiology at Cardinal Glennon Children's Hospital from 1962 until the early 1980s. He retired in 1983. During retirement he was associate professor emeritus of pediatrics at St. Louis University Medical Center. He received national attention for his hyaline membrane disease research in the 1960s. Dr. Fagan was past president of the St. Louis Cardiac Club and past member of the board of directors of the St. Louis Heart Association.

■ **Omer E. Hagebusch, M.D.,** Boca Raton, Florida, died September 10, 1992, at age 87. Dr. Hagebusch received his medical degree at St. Louis University School of Medicine in 1931. He was in private practice in St. Louis for 42 years before retiring in 1975. Dr. Hagebusch was past president of the medical staff at the old St. Vincent's Hospital in St. Louis County. He also served on the staffs of Incarnate Word, Bethesda and Missouri Baptist hospitals in St. Louis and Belleville Memorial, Centreville Township, St. Mary's hospitals in East St. Louis and St. Elizabeth Hospital in Granite City. In the 1930s he founded Clinical Laboratories. Dr. Hagebusch was a past president of the Missouri Pathology Society and an emeritus fellow of the American Society of Clinical Pathologists. He was chosen as Pathologist of the Year by the National Pathological Society in 1965. He was a former member of the St. Louis Metropolitan Medical Society, Missouri State Medical and American Medical Associations the board of governors of the American College of Pathologists.

■ **Melvin M. Schwartz, M.D.,** Richmond Heights, Missouri, died September 8, 1992, at age 68. Dr. Schwartz received his medical degree at the University of Nebraska, in 1947. He had been in private practice since 1953 and was president of Specialists In OB-GYN Inc. in Creve Coeur for the past ten years. Dr. Schwartz was on the staff at Barnes, Barnes-West, Jewish and Missouri Baptist hospitals and at St. John's Mercy Medical Center. He was past director of the St. Louis Society for Medical and Scientific Education and past president of the Social Health Association of Greater St. Louis, the St. Louis Metropolitan Medical Society and the Jewish Hospital Alumni Association. Dr. Schwartz was a member of the American College of Obstetricians and Gynecologists, American Physicians Fellowship, Inc., American Society of Clinical Hypnosis, and the American Society of Abdominal Surgeons.

■ **Clifford C. Wilson, M.D.,** Walnut Creek, California, died August 29, 1992, at age 90. Dr. Wilson received his medical degree at the University of Louisville School of Medicine, Louisville, Kentucky, in 1930. He practiced in Kansas City for 50 years until retiring in 1977. He was on staff at St. Luke's and Trinity Lutheran hospitals. He was a member of the American College of Surgeons, the American Proctologic Society and the Missouri State Medical Association.

University of Missouri - Columbia

MU's division of cardiology was a major participant in the Survival and Ventricular Enlargement Study (SAVE) which reported in the *New England Journal of Medicine* the early use of captopril reduces risk of recurring heart attacks. Participants included cardiologist **Richard Webel, M.D.**, associate professor of internal medicine, **Barbara Russell, R.N.**, **Sondra Flaker, M.Ed.**, and cardiology postdoctoral fellows **William Wright, M.D.**, and **Steve Jenkins, M.D.**

The Gift of Life (GOAL) group, has received a grant from the U.S. Department of Health and Human Services. This grant will allow the students to expand the program to other medical schools across the country. The group works with schools and community groups to dispel myths about organ and tissue donation.

James Hinson Jr., M.D., assistant professor and interim director of pulmonary, critical care and environmental medicine, has been voted Missouri governor-elect of the American College of Chest Physicians.

Wayne McDaniel, Ph.D., research assistant professor of cardiothoracic surgery, gave a presentation on pulsed current waveform for internal defibrillation at the Association for the Advancement of Medical Instrumentation's annual meeting and exposition in Anaheim, CA.

Robert W. McMurray, M.D., assistant professor of immunology and rheumatology, has been named a 1992 Senior Rheumatology Scholar by the American College of Rheumatology. The award, which includes a stipend from the college, honors the nation's most outstanding rheumatology trainees. Dr. McMurray received the award this October in Atlanta at the college's annual meeting.

Sara Walker, M.D., professor of immunology and rheumatology, presented "Prolactin as an Immunoregulatory Hormone" at the recent plenary session of the Pyschoneuroimmunology in Budapest, Hungary. The symposium was a satellite meeting of the International Congress of Immunology.

Karl Weber, M.D., professor and chairman of internal medicine, recently co-chaired a satellite symposium on "Aldosterone and Cardiovascular Disease: New Insights" and gave a presentation at the 14th Congress of the European Society of Cardiology in Barcelona, Spain.

Seventeen abstracts submitted by MU's department of internal medicine were accepted for presentation at the Central Society for Clinical Research meeting Nov. 4-6 in Chicago. They include research in cardiology, endocrinology, general internal medicine, hematology, and medical oncology, and nephrology. MU cardiologists also will present seven abstracts at the American Heart Association's Scientific Sessions Nov. 16-19 in New Orleans.

Several MU faculty gave presentations at the Federation of American Societies for Experimental Biology's annual meeting in Anaheim, CA. They included **Colette Wagner-Mann, D.V.M., Ph.D.**, research assistant professor of cardiothoracic surgery; and three pharmacology faculty: **Jesse W. Bowen, Ph.D.**, assistant professor; **Judith Cole, Ph.D.**, instructor; and **Michael R. Yordy**, Ph.D., research associate.

In *Beyond Yin and Yang: How Acupuncture Really Works*, author **George A. Ulett, M.D., Ph.D.**, clinical professor of psychiatry, debunks the main theory behind traditional Chinese acupuncture -- that thin needles inserted and twisted in "meridian" channels under the skin can alleviate or cure conditions in targeted organs throughout the body. Dr. Ulett and colleagues became the first researchers to receive funding for acupuncture research from the National Institutes of Health in 1972.

Their work points to success in pain relief when acupuncture is combined with low levels of electrical current. Of the 360 to 1,000 places on the body identified by traditionalists as acupuncture points, between 70 and 80 correspond to motor points, places where nerves enter muscle tissue. Utilizing these points, "electroacupuncture" stimulates the release of neuropeptides, which are essential to pain control.

Daniel Vinson, M.D., assistant professor of family and community medicine, and colleagues have created a computer program that challenges problem drinkers who may be headed for alcoholism to curb or eliminate their alcohol consumption by making a written agreement with their physicians.

Adult patients who visited the MU family practice clinic this summer for any reason were offered a quiz designed to identify problem drinkers. If they agreed to participate in the study, those who scored high enough were assigned either to go through a new software program called PACT (Programmed Alcohol Contracting Tool) or to be a control subject who receives only oral counseling about the problem. Patients will be followed up after one month and six months to see if and how their behavior has changed.

Patients are asked to indicate on a sliding scale how much of a problem alcohol is in their lives, what others think of the situation, and how much they are ready to change. Based on the responses, PACT directs users to do one or more of three things: think about their problem; plan for changing their behavior; and/or taking action to change how much they drink. Users reward themselves for completing the conditions by choosing the computer's suggestions or customizing a reward that appeals to them. The program ends by printing a contract describing the agreement.

St. Louis University

Roy H. Petrie, M.D., has been appointed as professor and chairman of the department of obstetrics and gynecology. The joint appointment is the result of an affiliation agreement with St. Mary's Health Center. St. Mary's will be the headquarters for obstetrics and gynecology education, research and clinical services provided by St. Louis University's medical school.

William S.M. Wold, Ph.D., was named professor and chairman of the newly formed department of molecular microbiology and immunology. Dr. Wold will oversee research and educational activities previously conducted in the department of microbiology.

Mark F. Jacquin, Ph.D., professor of anatomy and neurbiology, has been selected by the National Institutes of Health to be chairman of the neurological sciences study section in the division of research grants. Dr. Jacquin has also received a three-year grant from the National Institute of Neurological Disorders and Stroke to study how touch is processed in the cerebellum.

Maurice Green, Ph.D., professor and chairman of the Institute for Molecular Virology, has been awarded two five-year grants from the National Institute of Allergy and Infectious Diseases of the NIH. The award will further Dr. Green's research into the basic mechanisms of the AIDS virus.

Thomas J. Donohue, M.D., assistant professor of internal medicine in the division of cardiology, received a two-year grant from the American Heart Association, Missouri Affiliate Research Committee, to study how the heart responds to damaging heart attacks.

Richard S. Kurz, Ph.D., associate dean and director of the health administration program at the School of Public Health, has received a one-year grant from the U.S. Department of Health and Human Services.

Steven J. Fliesler, Ph.D., associate professor of ophthalmology, Bethesda Eye Institute, has been selected as a Research to Prevent Blindness James S. Adams scholar which includes a grant to further his studies of blinding eye diseases.

Daphne E. deMello, M.D., professor of pathology in the division of pediatric pathology, received a one-year grant from the American Lung Association to study how diabetes in a mother affects the lungs of her child.

George T. Grossberg, M.D., professor of psychiatry and human behavior and director of the division of geriatric psychiatry, has been named assistant editor the of new *American Journal of Geriatric Psychiatry*. The journal, which begins circulation in January, is a publication of the American Association of Geriatric Psychiatry.

Gary R. LaBlance, Ph.D., assistant professor of otolaryngology, chief of speech pathology and director of the voice laboratory, has been elected to a three-year term as a legislative counselor to the American Speech-Language-Hearing Association.

The cell and molecular biology graduate training program at St. Louis University has received a five-year renewal grant from the National Institute of General Medical Sciences of the NIH. The grant will help with the expenses of eligible students working toward a doctorate in the cell and molecular biology training program.

Kerry K. Assil, M.D., assistant professor of ophthalmology at the Eye Institute, is the creator of a new blade which St. Louis University ophthalmologists say will dramatically improve eye surgery.

The Genesis Blade is for use on patients undergoing radial keratotomy, a surgical procedure to correct vision in nearsighted patients. It is designed to improve upon the two methods, the uphill, or "Russian" method and the downhill, "American" method. In The Russian method cuts are precise and yield predictable results, but has a danger of cutting too far upward into the seeing part of the eye. In the American method the cutting into the seeing part of the eye is eliminated but the cut is not as precise and thus the results are unpredictable.

The new blade is sharp on both sides so it allows the surgeon to make the safer downhill cut but then reverse direction to make the more precise uphill cut as well. The significance of the blade design is that is has a safety feature, a dull point or "dead end" on the uphill side that prevents cutting too far into the seeing part of the eye and it will only retrace a cut that already has been made.

Orthopedic surgeons are using a new procedure to aid the healing of broken bones that have not mended after conventional treatment. Surgeons are studying the effectiveness of combining bone injections, and electrical stimulus at the fracture site.

Bone marrow is removed from the pelvis by needle and injected directly into the fracture site without making an incision. After bone grafting, patients wear a battery-operated, electrical device over the fracture site to stimulate the bone's healing process.

A new self-help book on social phobias is co-authored by psychologists in the Anxiety and Disorders Center in the division of behavioral medicine. The book titled, *Dying of Embarrassment: Help for Social Anxiety and Social Phobia*, by authors **Cheryl N. Carmin, Ph.D., Alec Pollard, Ph.D, Teresa Flynn, Ph.D.** and **Barabara Markway, Ph.D.,** is available in bookstores nationwide.

CME CALENDAR

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send this information for listing in *MISSOURI MEDICINE*. Please remember to include the name of the individual who can be contacted at your institution for additional information about your CME events.

November

Every week Oct. 5, 1992 to Oct. 1, 1993. AIDS, Malpractice, OSHA and Medicare. 28 resort-based classrooms. Contact American Educational Institute, Inc., 401 S. Woodward, Suite 333, Birmingham, MI 48009, 800/354-3507, fax 313/433-0615.

3 - *St. Louis*: St. Louis Surgical Society Fall Panel Discussion: The use of monoclonal antibodies in gram negative sepsis. Guest speaker R. Phillip Dellinger, M.D. from Ben Taub General Hospital. Contact John P. Hoehn, M.D., 314/569-6656.

5 - *St. Louis*: 1992 Pediatric Trauma: The Kaliedescope of Care. 7 credit hours. Contact Laura Kuensting, B.S.N., St. Louis University Medical Center, 577-5666.

5 to 7 - *Kansas City*: 70th Annual Fall Clinical Conference. Contact Linda F. Smutz, Kansas City Southwest Clinical Society, 7920 Ward Parkway, Ste. 206, Kansas City, MO 64114, 816/523-3383.

5 to 8 - *St. Louis*: The International Society for Applied Cardiovascular Biology & Washington University School of Medicine, 3rd Bennial Meeting Toward Application of Advances in Basic Cardiovascular Biology. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

6 - *Columbia*: OB/GYN Update 1992. Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.

6 & 7 - *Detroit, MI*: 40th Annual Detroit Trauma Symposium. Contact Marjorie Norum, Dept. of Surgery, Harper Hospital 3990 John R., Detroit, MI 48201, 313/745-8778.

6 to 8 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: Surgical Approaches to the Skull Base. 28 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

6 to 8 - *Rockville, MD*: Fourth Annual Infectious Disease Review. For more information contact, Svetlana Lisanti, Conference Coordinator, Center for Bio-Medical Communications, Inc., 80 West Madison Ave., Dumont, NJ 07628, 201/385-8080 or 800/231-0389.

7 - *St. Louis*: Perinatal Symposium 1992. 3 credit hours. Contact Barbara Kidd, St. Louis University School of Medicine, 314/768-8873.

7 - *Kansas City*: Current Concepts in Women's Health. Contact Kim Dwork, Office of CME, Saint Luke's Hospital, 44th & Wornall Rd., Kansas City, MO, 64111, 816/932-5140 or 800/451-3182.

9 - *St. Louis*: Transjugular Intrahepatic Porto-systemic Shunts (TIPS). City-Wide Radiology Conference by Ernest J. Ring, M.D. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

9 to 13 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: The 2nd Ugo Fisch Microsurgery of the Cranial Base Workshop. 40 credit hours. Contact St. Louis University School of Medicine, CME Office, 314/577-8167 or 800/553-2712.

10 to 12 - *St. Louis*: Doppler Echocardiography: The Quantitative Approach. 20 credit hours. Contact Dianne Reid, St. Louis University Medical Center, 314/577-8897.

12 & 13 - *Kansas City*: Tenth Annual Basic and Advanced Fetal Heart Rate Monitoring Seminar. 13 credit hours. Contact Carl Osborne, CME Office, St. Luke's Hospital, 816/932-3737.

12 to 15 - *San Antonio, TX*: Southern Medical Association 86th Annual Scientific Assembly. For more information SMA's Member Services Center at 800/423-4992 or 205/942-0642.

13 - *Kansas City*: Current Concepts in the Treatment of Breast Disease. 7 credit hours. Contact the Ed Bixby Institute for Postgraduate Medical Education, 9103 E. 39th St., Kansas City, MO 64133, 816/276-4306, in Missouri, 800/92-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.

13 to 15 - *St. Louis*: Nineteenth Annual Symposium, Anesthesia and the Geriatric Patient. Contact Geriatric Symposium, Dept. of Anesthesiology, Box 8054, Washington University School of Medicine, 660 S. Euclid, St. Louis, MO 63110.

14 - *St. Louis*: Ophthalmic Microsurgery Workshop Series - Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic Keratotomy. 7 credit hours. Contact Dr. Assil, Bethesda Eye Institutue, St. Louis University Medical Center, 577-8264.

18 to 21 - *Madras, India*: 2nd International Meeting of the Royal College of Physicians and Surgeons Medicine & Surgery 2000 AD. 22 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

21 & 22 - *St. Joesph*: Advanced Cardiac Life Support Provider Course. 16 credit hours. Contatct Barb Tunks, R.N., Heartland Health System Critical Care Educator, 801 Faraon, St. Joesph, MO 64501, 816/271-7859.

21 to 23 - *St. Louis*: Advanced Neurosurgery Workshop for Operating Room Personnel. Contact St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

December

3 & 4 - *Kansas City*: The Heart, 1992 Current Topics in Cardiology. Contact Beth M. Paul, Office of CME, Saint Luke's Hospital, 44th & Wornall Rd., Kansas City, MO 64111, 816/932-2301.

4 & 5 - *Kansas City*: Orthopedics for the Primary Care Physician. Category 1 credit hours not approved at this time. Contact Carol Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.

5 - *St. Louis*: Hypertension. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

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St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

12 - ***St. Louis*****: 4th Annual St. Louis University Symposium for Medical Directors in Nursing Homes.** 6 credit hrs. Contact Sue Wheat, St. Louis University School of Medicine, 314/577-8462.

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14 - ***St. Louis*****: Trauma Imaging.** City-Wide Radiology Conference by Stuart E. Mirvis, M.D. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

January

15 to 17 - ***St. Louis*****: Advanced Trauma Life Support Course.** 24 credit hours. Contact Mary Keegan, R.N., St. Louis University School of Medicine, 577-8365.

11 - ***St. Louis*****: City-Wide Radiology Conference.** For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

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Air Force	813
Army Reserve	770
Berlin-Wheeler	776
CompHealth Locum Tenens	813
Eli Lilly & Co.	774
HealthCare Administrative Services	808
Healthline Management Inc.	778
Jackson & Coker	780
Medical Defense Associates	815
Medical Protective Company	816
MOMEDICO	766
MonetaMed	777
Moore Jaguar	768
National Data Bank Response	776
Palisades Pharmaceuticals	802
Physician International	780
PIE Mutual Insurance Co.	818
RCA Mutual Insurance	784
Searle	820
Sedgwick James of Missouri	804
Trans Global	772

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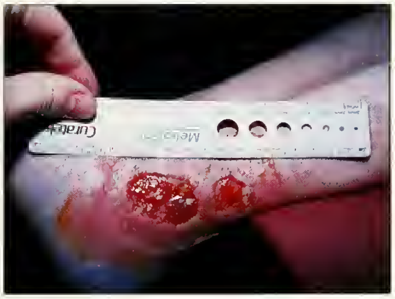
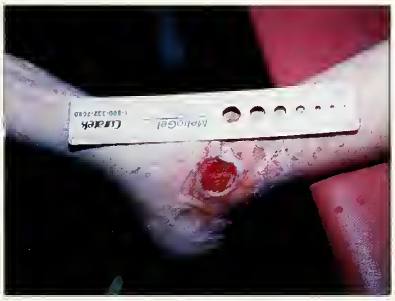
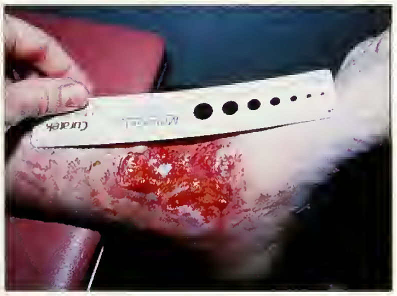
DERMATOLOGY QUIZ

The Dermatology Quiz is a new section that will continue in future issues of the magazine. Use it to test your knowledge.


Left ankle - Lateral


Right ankle - Medial


Left ankle - Medial

The patient is a 78-year-old white woman who has had chronic intermittent ulcerations on both lower extremities for 32 years. She has had multiple surgical procedures to correct this problem in the past, but the ulcers have always recurred in less than one year after each procedure.

She had enlarging ulcers for six months. The dull, aching pain when ambulating bothered her for years, and she had relief of the pain only when her legs were elevated. The wounds had drained blood tinged fluid, but she saw no pus, nor had fever or chills. She had no other illnesses, and specifically no history of diabetes mellitus, cardiac disease and deep venous thrombosis.

She was an alert and oriented elderly female in no distress. Her cardiac, respiratory and abdominal examination were normal. The carotid and radial pulses were normal. The dorsalis pedis pulse was absent bilaterally, but the posterior tibial pulse was intact. Sensation in the feet was intact, including proprioception and light touch. Skin examination of the lower extremity showed moderate hyperpigmentation and dry, scaling skin around the ankles. Four ulcers were present around the ankles. Each ulcer was shallow with a red, granulating base and a sharp border. The ulcer dimensions were as follows:

Left ankle:	Medial	5 x 4 cm
	Lateral-proximal	2 x 2 cm
	Lateral-distal	2 x 4 cm
Right ankle:	Medial	2 x 3 cm

??? Your Diagnosis ???

The history and physical examination of this patient most likely represents a diagnosis of

a. Arterial Insufficiency?
b. Venous Stasis Ulceration?
c. Neuropathic Ulceration?
d. Pyoderma Gangrenosum?
e. Atrophie Blanche?

See Page 801 for diagnosis and treatment discussion.

For the many faces of mild hypertension

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[*] The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

[†] Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

[‡] Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

2/13/92 • P92CA7196V

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:13I-15I. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve D, Hals D. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:102S-1029.

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Printed by the Ovid Bell Press, Inc., Fulton, Missouri 65251.

CONTENTS

VOLUME 89, NUMBER 12

MSMA Ombudsman's Update

Infectious Waste Management Guidelines for Missouri Physicians
Patrick J. Mills, CPA, MBA **836**

Perspectives

Biliary Nightmare
Leslie E. Tucker, MD **842**

Editor's Desk

Using Ethics Advisory Committees to Cope with Ethical Issues
Guest editorial by William A Nelson, PhD **827**

Index

Index to Volume 89 (January to December 1992) 850

Scientific Articles

Human Immunodeficiency Virus (HIV) Seroprevalence Surveys
Kenneth W Spare, BA, Judith Craig, MPA, Judith Moore-Nichols, MPA, Gerald L Hoff, PhD, Richard M Biery MD, MSPH, Kevin S. Gipson, BA, and Todd Baumgartner, MD, PhD **843**

Nodular Poorly Differentiated Lymphocytic Lymphoma of the Thyroid
Richard H Matthews, MD, PhD and Nuran Ercal, MD, PhD **846**

Departments

MSMA Officers, Councilors and AMA Delegates **825**
Letters to the Editor **833**
President's Message **835**
Auxiliary Message **841**
Physician Recognition Awards **859**
Practice Management **831**
New Members **861**
In Memoriam **865**
Medical School and Member News **867**
CME Calendar **868**
Classified Advertisements **871**
Information for Contributors **873**
Dermatology Quiz **857, 875**

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MEDICAL COLLEGE: University of Missouri, 1978

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MISSOURI MEDICINE

Journal of the Missouri State Medical Association

Vol. 89, No. 12 **December 1992**

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Using Ethics Advisory Committees to Cope with Ethical Issues

by William A. Nelson, PhD

Physicians face a growing number of ethical dilemmas in health care. There are many factors stimulating this growth. The rapid advances in medical technology and drugs have given patients good reason to expect that health care problems will be resolved. However, there are increasing questions surrounding the issue that just because we can do something, should we?[1] The evolution of sophisticated life-support technologies has enabled health care providers to forestall death. There are very few deaths today that do not involve decision-making at the end of life. It has been suggested that 70 percent of deaths in this country involve some negotiated agreement not to use available life-sustaining technology.[2] Ethical questions of who lives, who dies, who decides, and who pays are of growing concern. The ethical issues are not limited to the use of life-sustaining procedures or the "exotic" ethical issues concerning transplantation or various methods of human reproduction. Ethical issues abound concerning deceiving patients about the truth of their diagnosis or breaching confidentially concerning a HIV positive patient or the way a diagnostic code is entered onto a Medicare form. Ethical dilemmas are common whether one practices in the urban, academic or rural setting.

Another reason for the increase in ethical dilemmas is an outgrowth of the patient's rights movement; patients want to make their own decisions.[3] A recent *New York Times* series "Doctors in Distress" attributes the deterioration of the physician-patient relationship to a lack of trust, malpractice suits, and policies and regulations dictating care. Many patients have the feeling that medicine is just a business and physicians do not always act in their interest. They therefore want greater control over decision-making, especially decisions that relate to their personal lives.[4]

As a result of the interest in medical ethics we have witnessed a tremendous explosion of articles in the medical and philosophical literature, the number of ethics-related educational conferences, a recognition that medical ethics is an accepted component of a medical student's education, the evolving role of the medical ethicist, the desire of practicing physicians to expand their knowledge of ethics, and the development of ethics advisory committees in hospitals.

In the clinical setting physicians generally deal with ethical issues similar to the self-reliant manner in which they deal with medical problems; they apply the best knowledge they possess to the problem. When faced with an ethical dilemma health care providers tend to act in accordance with what they intuitively believe is the morally correct position. Physicians who have had a reasonable exposure to medical ethics are able to manage quite adequately the majority of ethical dilemmas encountered in their practice. However, a physician's knowledge of clinical ethics can certainly be enhanced by reading the many case-oriented medical ethics articles in medical journals. A physician should read a basic medical ethics text or anthology focusing on ethical theory and key conceptual issues.[5,6,7,8,9] The most important issue for the physician is to respond to ethical dilemma only after thoughtful and serious reflection based on moral reasoning rather than merely personal feelings or values

In medical ethics, as in any discipline, some problems are complex enough to justify consulting with people who have specialized in the area. This may mean contacting a medical ethicist. A growing number of academic based medical centers have ethicists on the faculty for teaching and clinical consultation. The physician in a rural setting should find out who these people

Editor's Note:

Advances in scientific and medical technology confront both the physician and society with new ethical challenges. Political and social evolution of changing perspectives creates ethical dilemma from situations that once seemed straight forward and non-controversial.

I requested William A. Nelson, PhD, to address the topic of hospital ethics committees in this guest editorial. Missouri presents a unique setting for these committees by virtue of having a diverse network of hospitals across the state. Some provide care to patients living in large urban centers and many others serve smaller rural communities. Missouri's prominent role in recent "Right to Die" cases and hospital based "abortion issues" have placed the state in the spotlight for ethical standards evaluation. Dr. Nelson is a nationally recognized expert in this field. I appreciate his contribution in this guest editorial.

J. Regan Thomas, MD, Editor

are and what is their availability for consultation long before an actual ethics case arises. This is similar to knowing who would be an available neurologist or oncologist consultant when confronted with such problems.

A hospital ethics committee is probably the best resource for health care providers to explore such dilemmas. Ethics advisory committees (EAC) have grown from an unconventional concept to a national trend. One of the early uses of the term "ethics committee" came from the New Jersey Supreme Court's ruling in the Karen Ann Quinlan case in 1976. There has been increasing support and acceptance for ethics committees from state medical associations, the American Hospital Association, and government organizations. Probably the most significant endorsement is from the number of ethics advisory committees that have spontaneously formed at large and small hospitals throughout the nation. The movement toward ethics advisory committees has resulted in the publishing of the Joint Commission's (JCAHO) 1992 "Patients Rights Standards" that states, "the organization has in place a mechanism for the consideration of ethical issues arising in the care of patients and to provide education to caregivers and patients on ethical issues in health care "(RI.2.2.61). Across the nation about 75 percent of hospitals have EACs. Ninety percent of VA Medical Centers have EACs according to a survey conducted by the Department of Veterans Affairs' National Center For Clinical Ethics (White River Junction, Vermont). Even in small rural hospitals ethics committees are common. For example, In Vermont, where 75 percent of hospitals have 100 beds or less, a 1988 survey of 12 hospitals reported 75 percent had ethics committees.[10]

The general purpose of an EAC is to provide a forum where health care professionals can discuss ethical issues with professionals who possess knowledge in applied ethics. More specifically the committee can promote the staff's ethical understanding, shape hospital policies, help physicians diffuse conflicts, disagreements or uncertainty, foster systematic moral reasoning, enhance communication, decrease hospital liability, and promote physician's and patient's moral rights.

The size of committees varies, but 8-12 members is an optimum number to create interdisciplinary discussions. Hospitals' ethics committees should be professionally diverse and comprised of at least physicians, nurses, chaplain or clergy, lawyer, social worker, and an administrator. Some EACs also have a lay person as a member. No one profession should dominate the membership. The differing viewpoints provided by a multi-disciplinary approach promotes the airing of various options and reasoning regarding a particular problem. The key criteria for membership are motivation, knowledge of ethics or at least a willingness to learn about medical ethics, and time. Because personal commitment is crucial to the effective functioning of the committee, it is best if members volunteer for membership. This means that the committee does not necessarily have to be made up of chairs of various departments.

The chair of the committee is particularly important and should be selected carefully. The chair can be from any profession but must possess the respect of the committee members and the institution. He or she must be perceived as knowledgeable in ethics, responsible, highly committed, and willing to take a stand. If the chair can not attend a meeting there should be an acting chair to facilitate the committee's activity.

The committee should be formally recognized by the medical center similar to other standing committees, with its own written policy indicating the EAC's purpose and functions. The policy should be published in the hospital's policy manual and reviewed periodically.

The committee should serve only in an advisory role. No one should be mandated to present an ethical dilemma to the committee and no one should be required to follow the advice of the committee. Committees use various titles, such as, "institutional ethics committee", "hospital ethics committee"; however, I prefer "ethics advisory committee" to emphasize the advisory nature of the committee.

The roles of EACs vary depending on the hospital and membership, yet there are three generally accepted roles. In the development of a new EAC the roles should unfold in the following order.

The first role is education. For the committee to achieve its overall goal the members must develop an understanding of basic conceptual issues in ethics as they relate to health care. In a large academic setting a committee could seek the expertise and knowledge of a medical ethicist to foster the education of the committee. Due to the likely absence of such a person in the rural setting there has to be an emergence of a local expert of medical ethics.[11] The local expert usually is a respected physician but could be any health care professional. The main criterion is someone who is willing to take the time to achieve self-education through reading the medical ethics literature and attending medical ethics conferences. This local expert is the key to the success of the committee and should serve as the chairperson. He or she should help the other members of the committee to develop a basic knowledge of applied ethics. The committee could invite an experienced medical ethicist or ethics consulting center to provide a local program to help review the basic issues in a medical ethics curriculum.[12] The committee should also be aware of state law related to health care issues. An attorney who specializes in health care law can be a helpful resource. The attorney's role on the committee is not to function as a risk manager. He or she should provide knowledge of relevant health related laws as it relates to ethics cases or policy consideration.

Once the committee members' knowledge of applied ethics has been enhanced the EAC can promote educational activities within the hospital by case conferences, topic oriented lectures, a journal club, ethics rounds, etc. The committee can also facilitate community-wide programs on such topics as living wills or other advance directives.

The EAC should not be perceived as having "all the answers." Its most fundamental role is to disseminate knowledge of applied ethics without threatening the sense of independence and self-reliance of physicians. When the committee is functioning effectively it is serving as an important resource to the administration, physicians and other health care providers, patients and family members.

The second role of the EAC is to review and draft ethics-related policy for the hospital. Common ethical problem areas, such as limitation of therapy, surrogate decision-making, confidentiality, and HIV testing, should have established policies. The best way to deal with ethical problems is to anticipate their occurrence and develop policy to serve as a basis for responding to common dilemmas. A properly educated EAC can develop sound ethical policy for the hospital. This activity can be very time consuming and not very exciting. Yet I have found it to be very important because of the broad implications of any policy. To draft ethically sound policy requires time, patience, and attention to detail. Secretarial support is obviously important and should be sought for every committee. Drafts of the policy, whether prepared by a subcommittee or an individual, must be circulated to the committee members before the meetings to ensure good discussion. Since most EACs meet monthly, it generally takes several months to draft a recommended policy before sending it to administration for approval. Despite this time-consuming process inherent in policy development it is important for the hospital to have a standing committee that can carefully draft ethics policy. This activity enhances the committee's standing within the institution by promoting reasoned ethical thinking.

The third role of the EAC is case consultation. There are several reasons why a physician or any health care provider should seek a ethics consultation: to enhance or confirm clinical ethical judgements, to clarify moral reasoning concerning patient care, and to seek recommendations for a clinical ethics problem which goes beyond the physician's expertise.

This case consultation role should be undertaken only after the committee feels competent in relating moral theory and basic conceptual issues, including competency, valid consent and refusal, and justified paternalism - to clinical situations. As Dr. Niemira suggests, "If the committee has done its homework and is politically astute, the transition from education to policy review and even consultation will be much smoother than anticipated."[13] Any member of the clinical care team should be able to consult with the committee. In providing ethics consultations, the following is a useful framework:

1. The committee reviews the facts of the case. What is the diagnosis? What are the treatment options? What is the prognosis? What is the patient's or (when the patient is incompetent) surrogate's desires? Many ethical problems are really disagreements about the facts of the case. Frequently, clarifying the facts decreases the conflict.
2. The committee clarifies the moral dilemma in the case.
3. The committee determines the morally relevant concepts. Is there relevant health law?
4. The committee decides how the concepts apply to the case.
5. The committee offers its advice, both verbally and with a chart notation.
6. The committee follows the case and reviews it at the next scheduled meeting.[14]

Depending on the number or urgency of case consultations, the committee does not usually function as a whole group in this process. The chair and one or two members should serve as consultants on a particular case and then report to the entire committee at the next scheduled meeting. I believe it is important to involve more than one member in case consultations so that the committee does not become dependent on one person. Also, if the committee is going to be available on an "on call" basis there should be a schedule involving several members. The committee should keep a log of all the cases that advice was offered which may include a copy of any chart notes.

A 1988 study reviewed 44 ethics consultations at the University of Texas Science Center in San Antonio. The study found that 98 percent of the physicians reported "learning much" from the consultations. The authors indicated that 89 percent of these consultations helped physicians clarify their thinking, 41 percent resulted in considerable changes in patient management, and 32 percent identified issues the physician had not recognized. The study also indicated that 93 percent of physicians gained increased self-confidence in making clinical ethical decisions.[15] This study demonstrates that an effective committee can foster effective clinical ethics decision-making which I believe enhances the quality of care.[16]

The members of the EAC may find it helpful to network with committees from other hospitals to share common concerns. Many states have networks for chairs or members of local committees. The network may gather once or twice a year for the exchange of concerns and experiences, assist one another, and facilitate education. Member committees have occasionally banded together to work with the state legislature to promote an ethics-related policy, such as, a durable power of attorney for health care law. Some networks have published a newsletter for member hospitals.

Despite the growing acceptance and increased role of EACs, I have some concerns. A committee will gain little respect if it attempts to dictate decision-making or policy to health care providers. Its purpose is to be an ethics resource. I get concerned if a committee is not adequately prepared to facilitate its function. Even though the JCAHO has stated that each hospital should have a mechanism for discussing ethical issues. the committee should not move too far, too fast, just like a runner preparing to run his or her first marathon. Before taking on the consultation role the committee needs to be adequately prepared. The committee should be an ethics committee, not a legal committee.

The committee should be aware of any pertinent laws or hospital regulations, but the committee is frequently dealing with issues that lack legal consensus or action. Therefore, since laws attempt to codify moral concepts and consensus it is important that committees use moral reasoning as the basis for their thinking. I also get concerned when the committee lacks broad based administrative support. This issue is waning across the nation but can be problem in some situations.

As noted previously I get concerned if the committee members have not volunteered, which can impact on their level of commitment. I get concerned if the committee is dominated by a particular person or particular profession. All members should have equal status on the committee. The chair (or acting chair) must ensure that all the members have an opportunity to articulate their thoughts. Periodically the committee should step back from its regular agenda to have a self-reflection process discussion. The committee should explore during the "special" self-reflect meeting; how is the committee functioning, how well are the members working together and with the institution, what process or committee policy should be changed?

Despite some of these concerns EACs are an important and valuable resource for every health care provider and the hospital administration. Both rural and urban health care providers need a forum to discuss the ethical ramifications of health care. An EAC is not another attempt to reduce the autonomy of health care providers, but rather is a useful resource to enhance the natural (and ethically appropriate) physician-patient or surrogate decision-making process. The EAC is important for the practitioner not only because it helps them think through complex cases, but also because it helps them understand and apply ethical thinking to basic decision-making. The EAC can serve as a source of insight and reasoning for the physician's practical decision-making. A local EAC is a valuable resource in fostering insight and understanding of ethical issues in clinical care.

The goal of an EAC is to enhance the excellence in patient care by emphasizing that good ethical decision-making is a fundamental component of good clinical care. Once EACs have reached a level of competence in applied ethics they can be an invaluable resource for coping with the frequent fogbound ethical issues and promote the goal of good clinician care.

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The Author

William A. Nelson, PhD

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Department of Veterans Affairs
Coordinator, Medical Humanities Section
Dartmouth Medical School

Dear Dr. Woerth,

Could you explain when a consult should be charged verses an office visit? There seems to be some confusion in our office regarding the correct billing of these services.

Dr. T.D.

Dear Dr. T.D.,

This is a common point of confusion for many offices and often results in lost revenue in medical offices. To know when to charge a consultation, you must first understand the definition of a consultation is a "service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source." Thus a consultation is one physician asking another physician for an opinion or advice about a patient's specific problem. The physician who requests a consultation needs to document in the patient's medical record to the need for the consultation. An example of how this might be documented in the patient record follows:

Nov. 5, 1992
Patient sent to Dr. Jones for consultation regarding abnormal EKG.

I highly recommend that the patient be given a referral note (you could use a prescription form) that includes this same message. The patient should be instructed to give this referral note to the consulting physician. The consulting physician then has proof that a consultation was requested.

The consulting physician, in addition to examining the patient for the specific problem indicated on the referral note, may initiate diagnostic services to help formulate his/her opinion or advice. The consulting physician can even initiate therapeutic consulting physician charges separately for any diagnostic or therapeutic services render **in addition to** the consultation fee.

The consulting physician must include in the patient's record his opinion and any services that were ordered or performed. This information must also be communicated to the requesting physician. Although it would be proper to communicate this information by telephone if the call was documented in the patient's record, I recommend that a written report be sent to the requesting physician and a copy of the report be retained in the patient's record. By establishing these "paper trails" (the referral note and a written report) there would be no question abut the validity of the consultation should a Medicare audit ever be conducted.

The "pre-operative clearance" is an example of a consultation. The surgeon (the requesting physician) that sends his patient to the patient's own cardiologist for preoperative clearance, is in fact requesting an opinion or advice. The surgeon wants to know if the patient can withstand the operation and if the cardiologist has any advice regarding the patient's condition. If all the documentation is made in the patient's records and a report is sent by the cardiologist to the to the surgeon, then it would be appropriate for the cardiologist to charge for a consultation. If the surgeon requests that the cardiologist assume responsibility for the patient's cardiac condition following the surgery, the cardiologist would charge all subsequent visits in the hospital using the subsequent hospital care codes (99231-99233).

How is a consultation different than on office visit? An office visit is one in which the patient (or a patient's family member) determines that he/she needs to see a medical specialist. The patient is examined for his/her condition, diagnostic and/or therapeutic services are rendered as needed. The office visit includes the history, physical examination and any counseling given by the physician and/or his/her staff. Any diagnostic laboratory, or therapeutic service rendered at the time of an office visit should be billed separately except the reading of an EKG and the administration of an injection. If the patient is seeing the medical specialist for a second opinion, the office visit codes should not be used. The appropriate code for a second opinion is a confirmatory consultation code. The level of confirmatory consultation code selected is dependent on the patient's condition.

Do you have a question for Dr. Woerth? Include your questions along with your name, address and phone number and send them to:

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Mail to: **NA&C, 11960 Westline Industrial Drive**
P.O. Box 460350, St. Louis, MO 63146-7350

Name of Prospective Insured Dependent

Doctor's Name

Residence Address

City/State/ZIP

Office Phone (To be used only if added info is needed)
(   )

Current Medical Specialty(ies)

Former Medical Specialty(ies) (for past 10 years)

List surgical procedures routinely performed

State(s) where currently licensed

States where formerly licensed (for past 10 years)

Amount of Professional Liability Insurance now carried
$

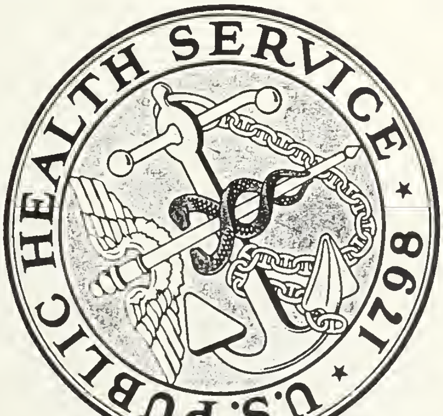
Is the doctor involved with delivery of babies? ☐ YES ☐ NO

02

CORRECTION: The November issue of *Missouri Medicine* falsely identified Richard Lagueruela, MD, as the subject of disciplinary action for sexual misconduct with a patient. The reported disciplinary action involved another physician. Dr. Lagueruela's name was erroneously substituted for the name of that physician in our report. There has never been any allegation of sexual misconduct against Dr. Lagueruela. We sincerely regret our mistake and apologize to Dr. Lagueruela for the embarrassment we have caused him.

Dear Dr. Wooldridge:

Enjoyed your "This - Not This!" article in the October 1992 issue of *Missouri Medicine*. Perhaps you know that the Public Health Service's emblem is the Caduceus of Commerce, crossed with a fouled anchor, signifying a seaman in distress.



John Cashman, MD, MPH
Medical Director ATT
(Retired Assistant Surgeon General, USPHS)
Lees Summit, Missouri

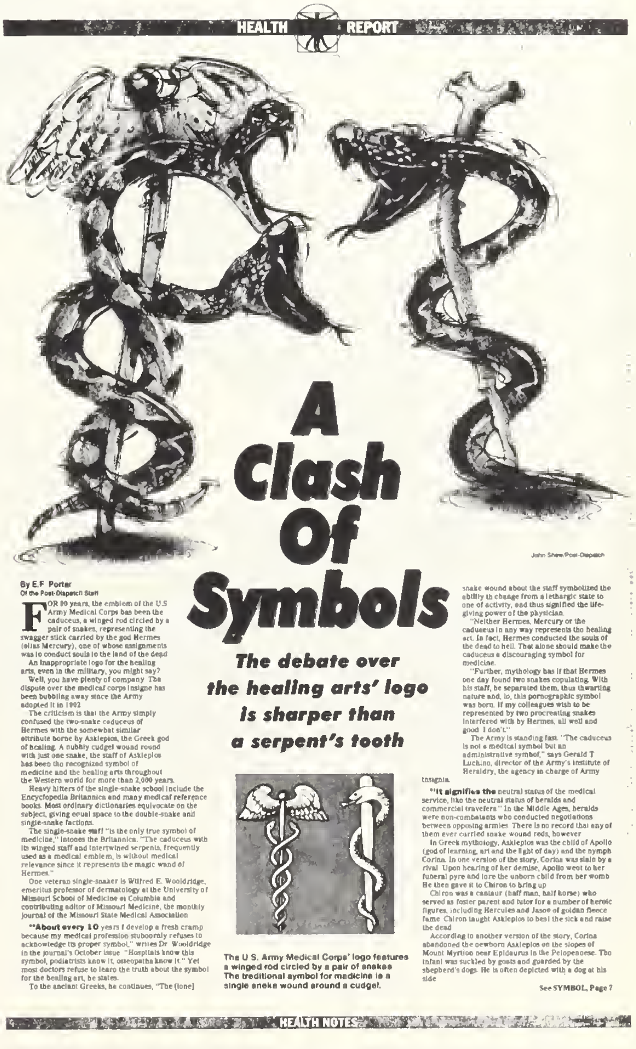
Dear Editor:
Huzzah for Dr. Wilfred Wooldridge (October 1992 issue). Like him, for years I have been fighting for the correct medical symbol, the one snake wound about the un-winged staff of Aesculapius, not the vulgar caduceus of Mercury. Dr. Wooldridge did not mention that in addition to his other negative attributes, Mercury (Hermes) was sometimes considered the god of Commerce. 'Nuff said?

James M.A. Weiss, MD, MPH, FACP, FRC Psych
Professor Emeritus of Psychiatry and of Family and Community Medicine
University of Missouri - Columbia

Editorial Note:

Dr. Wooldridge's guest editorial in the October 1992 issue of ***Missouri Medicine*** received wide readership. We received several letters to the editor (see page) and Dr. Wooldridge was quoted in an extensive article that dealt with the controversy in the Saturday, October 17, 1992 edition of the ***St. Louis Post-Dispatch.***

The MSMA does not use a medical symbol as a part of its logo or on its regular printings to members, but be assured that when such a device is called for - the single snake and staff always is the chosen symbol.



HEALTH REPORT

A Clash Of Symbols

The debate over the healing arts' logo is sharper than a serpent's tooth

John Shew/Post-Dispatch

By E.F. Porter
Of the Post-Dispatch Staff

FOR 90 years, the emblem of the U.S. Army Medical Corps has been the caduceus, a winged rod circled by a pair of snakes, representing the swagger stick carried by the god Hermes (alias Mercury), one of whose assignments was to conduct souls to the land of the dead.

An inappropriate logo for the healing arts, even in the military, you might say?

Well, you have plenty of company. The dispute over the medical corps insigne has been bubbling away since the Army adopted it in 1902.

The criticism is that the Army simply confused the two-snake caduceus of Hermes with the somewhat similar attribute borne by Asklepios, the Greek god of healing. A nubbly cudgel wound round with just one snake, the staff of Asklepios has been the recognized symbol of medicine and the healing arts throughout the Western world for more than 2,000 years.

Heavy hitters of the single-snake school include the Encyclopedia Britannica and many medical reference books. Most ordinary dictionaries equivocate on the subject, giving equal space to the double-snake and single-snake factions.

The single-snake staff "is the only true symbol of medicine," intones the Britannica. "The caduceus with its winged staff and intertwined serpents, frequently used as a medical emblem, is without medical relevance since it represents the magic wand of Hermes."

One veteran single-snaker is Wilfred E. Wooldridge, emeritus professor of dermatology at the University of Missouri School of Medicine at Columbia and contributing editor of Missouri Medicine, the monthly journal of the Missouri State Medical Association.

"**About every 10** years I develop a fresh cramp because my medical profession stubbornly refuses to acknowledge its proper symbol," writes Dr. Wooldridge in the journal's October issue. "Hospitals know this symbol, podiatrists know it, osteopaths know it." Yet most doctors refuse to learn the truth about the symbol for the healing art, he states.

To the ancient Greeks, he continues, "The [lone] snake wound about the staff symbolized the ability to change from a lethargic state to one of activity, and thus signified the life-giving power of the physician.

"Neither Hermes, Mercury or the caduceus in any way represents the healing art. In fact, Hermes conducted the souls of the dead to hell. That alone should make the caduceus a discouraging symbol for medicine.

"Further, mythology has it that Hermes one day found two snakes copulating. With his staff, he separated them, thus thwarting nature and, lo, this pornographic symbol was born. If my colleagues wish to be represented by two procreating snakes interfered with by Hermes, all well and good. I don't."

The Army is standing fast. "The caduceus is not a medical symbol but an administrative symbol," says Gerald T. Luchino, director of the Army's Institute of Heraldry, the agency in charge of Army insignia.

"**It signifies the** neutral status of the medical service, like the neutral status of heralds and commercial travelers." In the Middle Ages, heralds were non-combatants who conducted negotiations between opposing armies. There is no record that any of them ever carried snake wound rods, however.

In Greek mythology, Asklepios was the child of Apollo (god of learning, art and the light of day) and the nymph Corina. In one version of the story, Corina was slain by a rival. Upon hearing of her demise, Apollo went to her funeral pyre and tore the unborn child from her womb. He then gave it to Chiron to bring up.

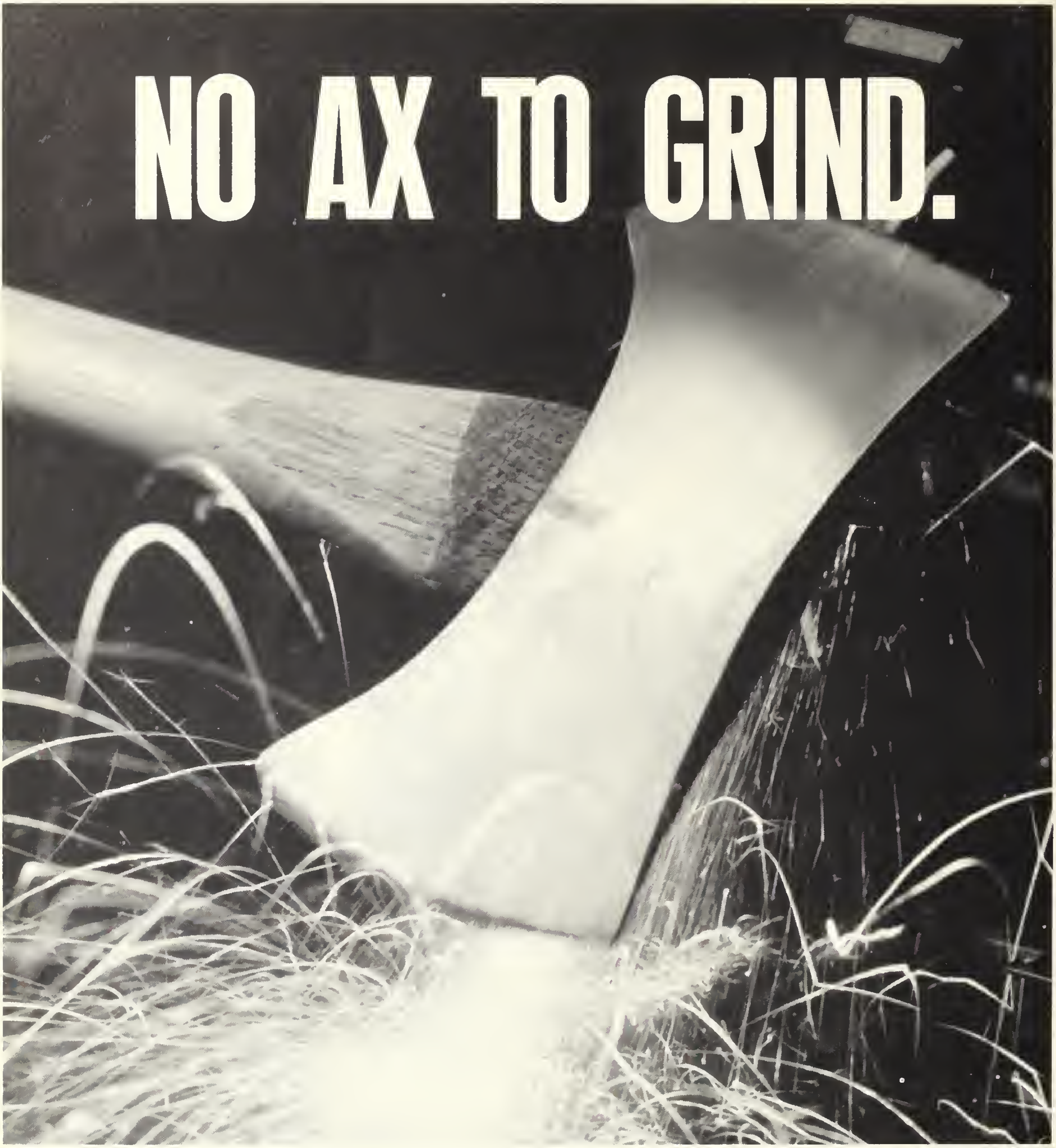
Chiron was a centaur (half man, half horse) who served as foster parent and tutor for a number of heroic figures, including Hercules and Jason of golden fleece fame. Chiron taught Asklepios to heal the sick and raise the dead.

According to another version of the story, Corina abandoned the newborn Asklepios on the slopes of Mount Myrtion near Epidaurus in the Peloponnese. The infant was suckled by goats and guarded by the shepherd's dogs. He is often depicted with a dog at his side.

See SYMBOL, Page 7

The U.S. Army Medical Corps' logo features a winged rod circled by a pair of snakes. The traditional symbol for medicine is a single snake wound around a cudgel.

HEALTH NOTES



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PHYSICIAN EXTENDERS

by

Carol Williams, MD

President, Missouri State Medical Association

Around the state physicians are being disciplined by the Board of Healing Arts because they are allowing nurses to diagnose and prescribe for patients whom the physician has not seen at a particular visit. The particular section of the Healing Arts Practice Act is 334.100(h) which spells out grounds for revocation or suspension of license and includes: "Signing a blank prescription form; or dispensing, prescribing, administering or otherwise distributing any drug, controlled substance or other treatment without sufficient examination or establishment of a physician-patient relationship - or writing of a prescription by anyone other than a properly licensed physician, including, but not limited to, the writing of prescriptions by anyone under a physician's supervision, control, instructions or protocol if such person is not a physician."

Among the physicians who have been disciplined under this section are those who have agreed to have their names used on prescriptions given out by nurse practitioners and certified nurse midwives working under protocols agreed to by both the physician and the nurse practitioner/nurse midwife. Many are physicians who have been recruited by the Department of Health, community health centers, and family planning clinics to provide necessary physician backup for advanced nurse practitioners. Many of these nurses are providing prenatal care, family planning, well-baby care and immunizations in areas where such services are not available and patients would not get care if "mid-level" providers were not available through these agencies.

The nurse practice act appears to conflict with the physician practice act in regard to what nurses may do and what they may not do. Physicians, not nurses, are being disciplined for cooperating with advanced nursing practice. While some advanced nursing practices are situated in private physicians offices, others are in rural clinics, community health centers, family planning clinics, and public health clinics where there are no physicians practicing. If the Board of Healing Arts continues to pursue its disciplinary actions against physicians who sign into protocols with advanced nurse practitioners, Missouri will continue to see a deterioration of basic medical services in rural and indigent inner city areas.

MSMA, in conjunction with the Missouri Association of Osteopathic Physicians and Surgeons and the Missouri Hospital Association, has begun trying to resolve the issue. Clearly we cannot ignore basic health care needs of so many Missouri citizens. Advanced nurse practice under protocols which define the limits of the nurse practitioner role and the supervision and consultative/referral role of the physician is one way that basic health care can be provided to under-served people. Forty states and the District of Columbia have defined a legal role for advanced nurse practitioners and have seen services improve to under-served populations. It is time for physicians in Missouri to decide whether or not we can forge a relationship with other health care professionals to move basic health care into the reach of more patients.

Infectious Waste Management Guidelines for Missouri Physicians

by Patrick J. Mills, CPA, MBA

Many members of physicians' office staffs have questions about infectious waste. This information (taken from a Missouri Department of Natural Resources (MDNR) technical bulletin) should assist small quantity generators of infectious waste. Specific questions should be addressed to the local MDNR Regional Office or to the Solid Waste Management Program at 314-751-5401.

INFECTIOUS WASTE

Infectious waste in Missouri is regulated as a nonhazardous solid waste under the Missouri Solid Waste Management Law. The law charges the MDNR and the Missouri Department of Health (MDOH) with the responsibility for regulation of infectious waste management. The MDOH is responsible only for regulating the on-site management of infectious waste by Missouri hospitals and for defining wastes which are considered infectious when produced by small quantity generators. The MDNR is responsible for regulating all other aspects of infectious waste management, including permit requirements, transportation, and packaging.

Included in the requirements for infectious waste management are the following major points:

1. All infectious waste must be treated before disposal in Missouri, except waste generated by an individual residence.
2. All sharps must be packaged in a rigid, leakproof and puncture-resistant container prior to transport and all treated and untreated sharps must be similarly packaged before disposal.
3. All treated waste must be certified as having been treated prior to disposal in a landfill in Missouri. The certification must be provided to both the hauler and the landfill. (See page 838 for a sample form)
4. The only requirement for infectious waste generated at an individual residence is that sharps be packaged in rigid, leakproof and puncture-resistant containers prior to disposal with the regular household waste. Other requirements discussed in the MDNR's bulletin (such as treatment, transport and certification) do not apply to infectious waste generated at an individual residence.

DEFINITIONS

Infectious waste is defined as "waste capable of producing an infectious disease because it contains pathogens of sufficient virulence and quantity so that exposure to the waste from a susceptible human host could result in an infectious disease." All infectious waste must be treated before disposal in Missouri except when the waste is generated by an individual residence. Infectious waste generated in individual residence must be properly packaged as described earlier in these article.

A small quantity generator (SQG) of infectious waste is defined as a generator of 100 kilograms or about 220 pounds or less of infectious waste per month.

The Missouri Solid Waste Management Law required the MDOH to specify infectious waste that must be rendered innocuous regardless of quantity. The MDOH specified that small quantity generator infectious waste includes the following categories:

1. **Sharps** - Discarded sharps including hypodermic needles, syringes and scalpel blades. This definition includes broken glass or other sharp items that have come in contact with material defined as infectious.

2. **Cultures and stocks of infectious agents and associated biologicals** - included in this category are all cultures and stocks of infectious organisms as well as culture dishes and devices used to transfer, inoculate and mix cultures.

3. **Other wastes** - Those wastes designated by the

medical authority responsible for the care of the patient which may be capable of producing an infectious disease.

Discarded sharps must always be handled as infectious waste and must always be properly packaged before transport and/or disposal. Cultures and stocks of infectious agents and associated biologicals also must always be handled as infectious waste unless generated by an individual residence. It is the responsibility of the health care professional, however, to determine whether any other items should be considered infectious waste when produced by a small quantity generator.

ON-SITE TREATMENT

Anyone generating infectious waste may choose to treat that waste on-site to render it innocuous. Such on-site treatment of infectious waste does not require a permit or approval from the MDNR, except that on-site incineration will require a permit from the MDNR Air Pollution Control Program or from a local air pollution control agency. Some treatment methods may result in the discharge of liquids and may be regulated by the MDNR Waste Pollution Control Program or the local sanitary sewer district. Hospitals choosing to treat infectious waste must comply with the requirement of the MDOH. Methods for on-site treatment include incineration, steam sterilization (autoclave) and chemical treatment.

For chemical treatment of sharps, the MDOH recommends the use of one part chlorine bleach mixed with nine parts water. The solution must then be carefully poured off so that free liquid does not remain in the container. The solution may be disposed of in the sanitary sewer system. The sharps container must then be sealed prior to disposal.

OFF-SITE TREATMENT

Infectious waste transported off the premises of the generator must be taken to a permitted infectious waste processing facility. In order for a hospital to be approved to accept infectious waste from SQG's, the hospital must submit a request for approval to both MDNR and MDOH. Requirements for such request are specified in 10 CSR 80-7.011 and 19 CSR 30-20.020. Hospitals may contact the Solid Waste Management Program for information pertaining to the approval process.

Packaging of Untreated Infectious Waste:

All sharps must be packaged in rigid, leakproof and puncture-resistant containers prior to transport and/or disposal. Prior to transport, all infectious waste must be placed in rigid or semi-rigid, leakproof containers clearly marked with the universal biohazard symbol, must be labeled with the words "Infectious Waste" or "Biohazard Waste" and must be sealed. There is no requirement for color of the container. Neither plastic bags nor glass containers may be used as primary containers for transportation of the waste - if these types of containers are used they must be placed within a container which fits the description of rigid or semi-rigid and leakproof. If glass is present, the primary container must protect the glass from breakage. Reusable containers must be constructed of either heavy wall plastic or noncorrosive metal and must be cleaned and sanitized before reuse.

Transportation of Untreated Infectious Waste:

If a SQG chooses to utilize an off-site processing facility for management of its infectious waste, two options for transportation exist. The generator may transport the properly packaged waste using its own employees and vehicles provided the vehicles are closed and secure. If the SQG chooses not to transport its own waste, the waste must be transported by a hazardous waste transporter licensed in Missouri for the transportation of infectious waste.

If the waste is transported off the premises of the generator, it must be taken to a permitted infectious waste processing facility, a hospital approved by both the MDNR and MDOH to accept such waste, or out of the state.

Tracking Documents for Untreated Infectious Waste:

If a SQG transports its own infectious waste to an approved hospital, the generator must provide records required by the hospital receiving the waste. If the generator transports its own waste to a processing facility, or if a licensed transporter is used, tracking documents must be prepared by the generator in accordance with 10 CSR 80-7.010. The transporter or the receiving facility may provide the forms, although they are not required to do so.

DISPOSAL

Section 260.203.2, RSMo, prohibits the placement of untreated infectious waste in a solid waste disposal area in Missouri, with the only exception being infectious waste generated by an individual residence. Sharps from an individual residence are not required to be treated, but must be properly packaged as described in this bulletin.

tious waste in Missouri must certify to the hauler and to the landfill that the waste has been rendered innocuous and may legally be placed in a landfill.

Packaging of Sharps for Disposal:

Prior to disposal, all sharps must be packaged in rigid, leakproof and puncture-resistant containers. This requirement applies to all sharps, including those which have been treated and those which have not been in contact with infectious agents.

Suitable containers for such packaging include commercial sharps containers which are rigid, leakproof and puncture-resistant, as well as any other type of container which meets these requirements. Commonly found containers which may fulfill this purpose include containers of heavy gauge plastic which may be sealed (for example, bleach bottles, anti-freeze containers, liquid laundry detergent bottles) and metal containers which may be sealed (for example, coffee cans with the lid in place and sealed with heavy-duty tape). A container should not be used for sharps which are to be treated if that container has a residue which may react adversely during the treatment technique. All containers should be thoroughly rinsed before use as a container for sharps.

Certification of Treated Waste:

Treated infectious waste which is to be placed in a landfill in Missouri must be certified as having been properly handled. The generator must supply this certification document (see this page for a sample form) to both the sanitary landfill and to the waste hauler.

Requirements for information to be included in the certification document must include the following information, at a minimum:

- the name, mailing address, location (when different from mailing address), and phone number of office/facility treating the waste.
- The printed name and signature of the person responsible for the treatment process.
- a brief description of the treated waste (e.g. sharps in metal containers).
- a brief description of the method of treatment.
- a statement that the waste has been managed in accordance with the Missouri Solid Waste Management Law and rules and may legally be placed in a landfill.

The certification must be revised when changes in the operation result in a change in the information provided. Copies of the revised certification document must be provided to both the waste hauler and the landfill.

-SAMPLE CERTIFICATION FORM-

Treated Infectious Waste

Treatment Facility
Name______________________________
Location______________________________
Mailing Address__________________________
Telephone______________________________

Treated Waste Description

_____ **Sharps in metal container**
_____ **Sharps in heavy gauge plastic containers**
_____ **Incinerator ash**
_____ **Laboratory wastes in autoclave bags**
_____ **Other (please specify)** _______________

Treatment Method

_____ **Steam sterilization**
_____ **Incineration**
_____ **Chemical Sterilization**
_____ **Other (please specify)**_______________

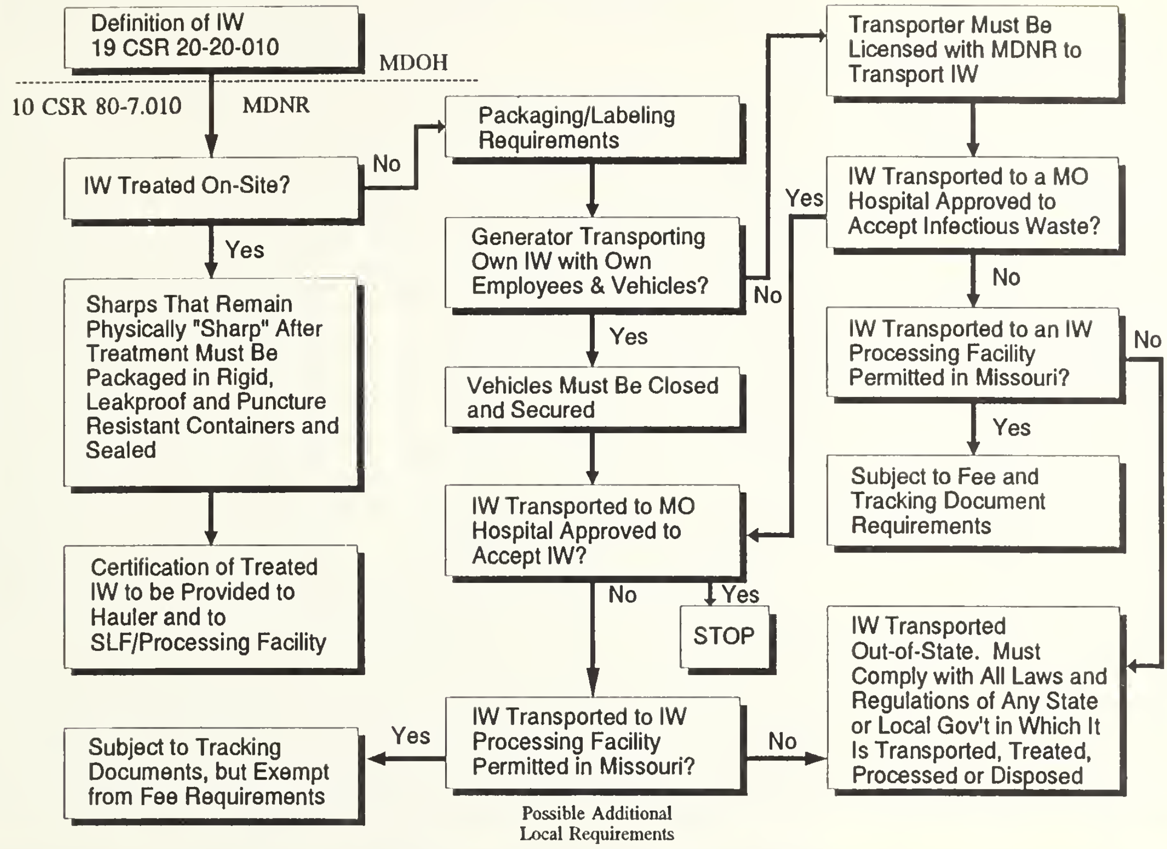
Certification

I certify that the aforesaid infectious waste has been managed in accordance with the Missouri Solid Waste Management Law and respective rules, and that it may legally be placed in a sanitary landfill.

____
Treatment Facility Manager, Officer, or Agent (please print)

____
Signature **Date**

NOTICE: This form was designed by the Missouri State Medical Association, the Missouri Dental Association, the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri Hospital Association, and the Missouri Veterinary Medical Association to comply with Section 260.203 RSMo (Supp. 1988) of the Missouri Solid Waste Management Law. It may not be in complete compliance with all local solid waste treatment requirements.



MANAGEMENT OF INFECTIOUS WASTE

Small Quantity Generators

Definition of IW
19 CSR 20-20-010
MDOH
10 CSR 80-7.010
MDNR
IW Treated On-Site?
No
Yes
Sharps That Remain Physically "Sharp" After Treatment Must Be Packaged in Rigid, Leakproof and Puncture Resistant Containers and Sealed
Certification of Treated IW to be Provided to Hauler and to SLF/Processing Facility
Packaging/Labeling Requirements
Generator Transporting Own IW with Own Employees & Vehicles?
Yes
No
Vehicles Must Be Closed and Secured
IW Transported to MO Hospital Approved to Accept IW?
No
Yes
STOP
IW Transported to IW Processing Facility Permitted in Missouri?
Yes
No
Subject to Tracking Documents, but Exempt from Fee Requirements
Possible Additional Local Requirements
Transporter Must Be Licensed with MDNR to Transport IW
IW Transported to a MO Hospital Approved to Accept Infectious Waste?
Yes
No
IW Transported to an IW Processing Facility Permitted in Missouri?
No
Yes
Subject to Fee and Tracking Document Requirements
IW Transported Out-of-State. Must Comply with All Laws and Regulations of Any State or Local Gov't in Which It Is Transported, Treated, Processed or Disposed

OTHER REQUIREMENTS

In addition to these state requirements, counties or municipalities may have additional requirements for the management of infectious waste. Managers of offices that generate small quantities of infectious waste should contact their county and city health departments to learn of these requirements.

Reference

1. *Management of Infectious Waste by Small Quantity Generators.* Jefferson City, Missouri: Missouri Department of Natural Resources; Revised August 1991.

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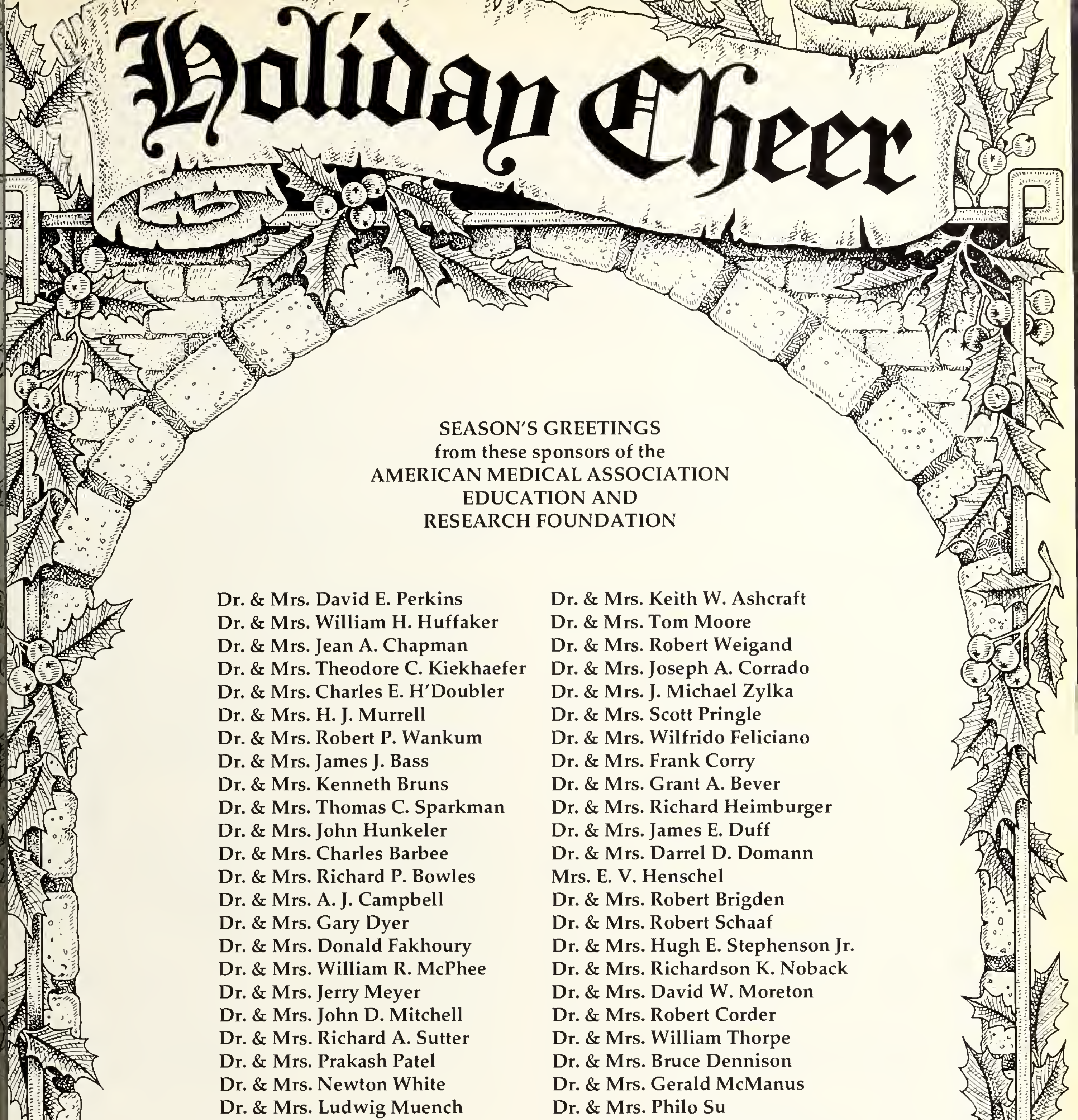

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BILIARY NIGHTMARE

by Leslie E. Tucker, MD

She awoke at night with a groan,
The ultrasound confirmed it was a stone.

She dreaded the scar, the six day stay,
All the pain, missed work, no pay.

No worry, I said, I can fix it in a novel new way,
Laparoscopic surgery, child's play.

No incision, no scar, your abdomen still pristine,
Minimal pain, tomorrow you can play eighteen.

She was given informed consent,
all the complications and such,
Said it all seemed a bit too much.

Entered the hospital, no fear nor dread,
It never occurred to me that she might soon be dead.

I thrust in the trocar as I oughta,
Barely missed piercing the aorta.

Pneumoperitoneum established, now asleep,
under the influence,
I began the search for the hilar confluence.

Pulled up the gallbladder and peered through the scope,
Anatomy looks different, know it I hope.

First case, no assistant to help, my dissection
lacked exposure,
I started to lose my composure.

Skipped the cholangiogram, too hard, no time, no fun,
I'm pretty sure that's the infundibulum.

Oozing of blood, started to suck,
What was that, the cystic duct?

Now I was nervous, was it the tea,
The oozing got worse, just couldn't see.

Had to stop the bleeding fast,
Time to use the laser blast.

Must act now, no time to quibble.
Fired the laser, things started to sizzle,

The abdominal cavity was soon full of smoke,
I was shaken and started to choke.

Things cleared and I saw what I had done,
The gallbladder was cooked, a steak well-done.

Finished the procedure and got out of there,
Hoping for the best was my prayer.

She developed severe post-operative pain
and it didn't go away,
So in the hospital she had to stay.

One week later, she was yellow,
Called on the expertise of my radiology fellow.

PTC revealed that the duct was blocked,
Transected the bile duct, I was shocked!

Drains were placed to decompress,
bide time to get out of this mess.

Unlike Nixon, I'll destroy the video-tape,
No pictorial evidence for them to gape.

What now my destiny, my *summons*,
was my *plaintiff* cry,
Must do a hepaticojejunostomy or she will die?

I woke up drenched with sweat and started to scream,
I realized that it had only been a bad biliary dream.

◆

Dr. Tucker specializes in Internal Medicine.
He lives in Washington, Missouri.

Human Immunodeficiency Virus (HIV) Seroprevalence Surveys

Kenneth W. Spare, BA, Judith Craig, MPA, Judith Moore-Nichols, MPA, Gerald L. Hoff, PhD,
Richard M. Biery, MD, MSPH, Kevin S. Gipson, BA, and Todd Baumgartner, MD, MPH

The seroprevalence surveys being conducted in the Kansas City area have to date tested 15,778 persons and resulted in 85 seropositive HIV tests. The sexually transmitted disease (STD) surveys and women's surveys fall in the lowest quartile of the combined national surveys. The drug treatment (IVDU) survey data were comparable to the median national seroprevalence of 3.8%. Seroprevalence rates in the STD surveys were 41 times that of women's surveys, and the IVDU surveys were 104 times that of the women's surveys. Based on three years of data from clinics with stable populations presenting for treatment, no trends in the demographics of those being found seropositive were identified to be statistically significant. This lack of trends has been presented as the normal findings of surveys nationally. The data does not show an acceleration of new infections based on seropositives being identified in the survey sites.

Public health agencies employ a variety of instruments to determine disease trends and understand the changing characteristics over time of a disease in the community. Each type of instrument has inherent biases. As part of the surveillance system to monitor the human immunodeficiency virus (HIV), blinded surveys are conducted annually in 44 standard metropolitan statistical areas (SMSAs) in selected sentinel sites. The objectives are 1) to provide state and local health officials with information on the levels and trends of HIV infection in various local groups considered to be at potential risk. Information is to be used to develop, focus, and evaluate education and prevention programs.[1]; 2) to indicate on a regional and national basis changes of prevalence and incidence over time for the infection in the various behavioral, demographic and geographic subgroups.; and 3) to project the number of persons who will develop HIV associated morbidity and who will require medical care.

Since January of 1989 the Kansas City Standard Metropolitan Statistical Area (KCSMSA) has been participating in the nationwide group of surveys instituted by the Centers for Disease Control (CDC). The design of these surveys has been described elsewhere.[2] These surveys are designed to provide data on trends unbiased by self selection or individual program initiative. The surveys are designed to be repeated on a yearly basis and capture a "snap shot" of the disease characteristics in the participating clinics within each SMSA. The funding for the KCSMSA (Johnson, Leavenworth, Wyandotte counties-- Kansas; Cass, Clay, Jackson, Platte, Ray counties -- Missouri) was awarded to the Missouri Department of Health (MDOH), which in turn subcontracted the implementation to the Kansas City, Missouri, Health Department (KCMO). With the cooperation of the Kansas City, Kansas -- Wyandotte County Health Department (KCKS), these surveys have been implemented in two sexually transmitted disease clinics, (STD), three women's health clinics (2 abortion clinics, 1 family planning), and one intravenous drug user clinic (IVDU). This article is based on data collected from the beginning of the surveys in January, 1989 through June 30, 1991.

CASE MATERIAL

The national CDC survey protocols ensure that all information is collected in an anonymous, blinded fashion.[3] All clinic patients were included in the survey with the exception of: 1.) Persons returning for follow up visits, 2.) persons referred to the clinic as a contact of known HIV seropositive individuals, and 3.) persons seeking only an HIV test. Each year, the goal was to obtain 1500 specimens from the STD clinics and 100 specimens from the women's surveys. The IVDU clinic survey included all new entrants into treatment. Serum specimens for examination were obtained from blood specimens taken for other purposes in the clinics. No blood was drawn specifically for use in the surveys. By the protocol, all laboratory tests were conducted by the MDOH according to prevailing techniques.

Demographic and risk behavior information were obtained where routinely available from normal clinic processes. Clinic specific information was collected on reasons for visit and diagnosis. The data was recorded on

Table I

Cumulative Seroprevalence Survey Data

Survey Type	Total # (Tested)	Total HIV+	% HIV +
STD	7347	76	1.034
Male	4306	71	1.649
White	665	26	3.91
Black	3477	41	1.179
Hispanic	143	4	2.797
Asian	10	-	-
Amer. In.	5	-	-
Undeterm.	1	-	-
Female	3034	5	0.165
White	538	1	0.186
Black	2422	4	0.165
Hispanic	58	-	-
Asian	5	-	-
Amer. In.	4	-	-
Undeterm.	-	-	-
Women's	8167	2	0.025
White	4160	-	-
Black	3567	2	0.056
Hispanic	175	-	-
Asian	62	-	-
Amer. In.	15	-	-
Undeterm.	188	-	-
Drug Treatment	264	7	2.65
Male	163	5	3.07
White	124	4	3.226
Black	36	1	2.778
Hispanic	1	-	-
Female	98	2	2.041
White	76	2	2.632
Black	21	-	-
Hispanic	1	-	-
Total	15778	85	0.539

Note: Table includes survey data through June 30, 1991 prenumbered computer scan forms. The number on the scan form eventually was assigned to the serum specimens, and all other patient identifiers were removed from the serum specimen. The information recorded on the forms was fed into a computer at the KCMO HIV/AIDS Program office. The resultant database was transferred to the MDOH, where the demographic and test result data were merged. The completed data then was returned to the KCMO HIV/AIDS Program for analysis by clinic site, and sent on to the CDC to be added to the national survey database.

DISCUSSION

The combined surveys tested 15,778 persons, 85 of those tested were found to be seropositive for HIV infection (Table 1). In total 11,299 (72%) were female, and 4,469 (28%) were male. Sex specific seropositive findings were 9 (0.08%) females and 76 males (1.70%).

The majority of the seropositives identified were found in the STD surveys (76 of 85). The highest percentage seropositivity by survey type was in the drug treatment survey (2.65%) with STD surveys next (1.034%) and women's surveys lowest (0.025%). Comparison of the demographic profiles of the surveys by year per clinic showed a stable demographic profile.[4] In other words, the profiles of the persons presenting for treatment at the clinics were very similar from year to year. The same was true for the seropositives identified in the STD surveys. While individual surveys may have had variation in the sex or race of seropositive persons identified, the variations were not statistically significant.

Nationally, the HIV seroprevalence rates analyzed for 54 of the 114 sexually transmitted disease clinics participating in the CDC family of surveys ranged from 0.0-39%, with 73% of the clinics having rates less than 4%, and 22 % with rates less than 1%. The combined cumulative seroprevalence rate in the KCMO STD surveys puts the Kansas City SMSA in the lowest quartile. That the majority of the HIV seropositive individuals were males, with a higher rate among whites than blacks, and that the predominate risk factor was being gay or bisexual. These observations are consistent with the results of voluntary programs conducted in the clinics.[5]

The data collected nationally in 143 of the 187 participating women's clinics, resulted with HIV seroprevalence rates ranging from 0.0-2.6%, with the median seroprevalence of 0.2% (1 seropositive per 500 samples). Of the survey sites included in the analysis 45 (31%) had a 0.0% seropositivity and 20 (14%) greater than 1%. The majority 78 (55%) were between 0.0-1%. The cumulative seroprevalence indicated at the Kansas City SMSA women's surveys placed in the lowest quartile. With only 2 of 8,167 persons seropositive, no demographic comparisons are possible. The ratio of seropositives to those tested was eight times lower than the median observed nationally.

Analyzed data from 54 of the 114 drug clinics participating nationally in the surveys ranged from 0.0-48.2%. The national median seroprevalence was 3.8% for men and 3.7% for women. Rates for males were generally similar to rates for females in the same centers. Rates by center, were on balance, somewhat higher for blacks and Hispanics than for whites, but the disparity between racial and ethnic groups was inconsistent and varied by metropolitan area. In the drug survey data for the Kansas City SMSA the median seroprevalence rate for females was 2.04% and for males 3.07%. Although the number of seropositives was low the racial mix suggests a higher infection level among whites, 6 of 7 individuals.

The important finding here is that, based on data spanning three years in clinics with stable populations presenting for treatment each year, changes in the demographics of those being found seropositive for HIV infection are not significant. The data does not show an acceleration of new infections based on seropositives being identified in the survey sites. The data also show that the passing of infection to others continues.

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Nodular Poorly Differentiated Lymphocytic Lymphoma of the Thyroid

by Richard H. Matthews, PhD, MD and Nuran Ercal, PhD, MD

A 44-year-old woman had a four-month history of enlargement of her thyroid. Evaluation revealed a rare disease: nodular, poorly differentiated lymphocytic lymphoma of the thyroid (NPDL), stage IE.

A review of the literature revealed that most thyroid lymphomas are diffuse histiocytic (DH). Treatment of thyroid lymphocytic lymphoma and survival rates have been quite variable between institutions. There are no large studies to guide the physician in making a management plan to treat thyroid NPDL. Our patient was treated with a combination of chemotherapy and radiation therapy (XRT).

Primary thyroid lymphomas are uncommon. They represent only 4%-5% of all thyroid gland malignancies.[1,2] They also represent only 2% of all extranodal lymphoma, occurring at approximately one-tenth the frequency of gastrointestinal lymphoma.[3] Thyroid lymphoma usually occurs in the sixth decade of life,[4] and predominantly among women, unlike lymphomas at most other sites.[5] There is an association of Hashimoto's thyroiditis with thyroid lymphomas,[6] and chronic lymphocytic thyroiditis is more likely to occur in middle-aged to elderly women.[7] It is therefore possible that the overall increased incidence of thyroid lymphomas in women might be related to the higher incidence of thyroiditis among women.[8]

Most extranodal lymphomas, including those of the thyroid, are diffuse histiocytic lymphomas (DH).[9] Nodular poorly differentiated lymphocytic (NPDL) lymphoma is a truly rare disease in the thyroid, estimated to represent about 2.5% of primary thyroid lymphomas.[8]

Reports differ in their evaluation of the prognosis for patients with thyroid lymphomas.[10,11] Some of this variance may be due to differences in the clinical staging, histopathological classification, and treatment employed. Treatment of thyroid lymphomas has included surgery, chemotherapy, radiation, or combinations thereof.

Treatment of NPDL of the thyroid poses basic conceptual problems: The specific disease entity is sufficiently rare that there are no large series available to guide one in making a management plan. Should the physician think of this as thyroid lymphoma, which is usually DH, as it usually is, or of NPDL in general, as it occurs at other sites?

Case Patient Report and Main Findings

A 44-year-old white woman complained of a progressively enlarging mass in her neck. In December 1989, this mass was in the vicinity of her thyroid and she began taking levothyroxine (Synthroid), but she experienced progressive weakness and fatigue. A thyroid scan showed an enlarged thyroid with asymmetric uptake, and a computed tomographic scan revealed bilateral thyromegaly with multifocal areas of pathologically low density bilaterally, more so on the left side.

The left lobe of the thyroid and isthmus of the thyroid were excised on April 10, 1990, yielding a pathological diagnosis of nodular poorly differentiated lymphocytic lymphoma. This diagnosis was confirmed by several pathologists.

Subsequent evaluation included computed tomographic scans of her neck, chest and abdomen; these failed to reveal any additional areas of disease, and the patient was referred to the radiation oncology service for treatment. She had not received prior radiation therapy. The patient denied any recent weight loss or fevers, but admitted to night sweats that had occurred on a weekly basis for the past five months. She denied any history of cancer, exposure to toxic chemicals, AIDS, or pre-existing diagnosis of Hashimoto's thyroiditis.

The pathology slides were reviewed and it was considered impossible to confirm or refute coexistent Hashimoto's thyroiditis. Tests for hypertension, diabetes, and connective tissue diseases gave negative results. Physical examination revealed a well-healed, horizontal surgical scar in the lower part of the neck. There was some residual fullness of the thyroid on the right side. The patient did not have any suspicious lesions in Waldeyer's ring or palpable lymph nodes. There was no icterus, abdominal tenderness or mass. The results of a central nervous system examination were within normal limits. Blood count, electrocardiogram, bone marrow, and lactic dehydrogenase test results were all within normal ranges.

A management plan for treatment of this patient's illness was decided after a discussion with a medical oncologist. The objective of the two-step plan was to cure this young, otherwise healthy, woman of her nodular lymphoma of the thyroid. First, she was given three courses of chemotherapy using cyclophosphamide, doxorubicin, vincristine and prednisone ("CHOP"-- Cytoxan|/Adriamycin|/Oncovin|/prednisone). The patient's night sweats ceased after the first course of chemotherapy.

Next, the patient received radiation therapy using a thyroid mantle. She was given 46 Gray tumor dose (Gy TD) in 23 fractions of 6 MV x-rays. The field was weighted 2:1 in favor of the anterior and a posterior spinal cord block was placed after the patient had received 38 Gy TD.

The patient tolerated her treatment well and remains free of disease two years after completing the chemotherapy and radiation therapy.

Comment

Early reports[12,13,14] of thyroid lymphomas reflected inconsistent use of radiation therapy or primitive techniques, and survival rates were poor. This pattern of poor survival statistics continued in some series reported in the 1980s.

An Austrian study reported in 1983,[15] in which only 40% of the patients received unspecified radiation therapy postoperatively, found all 31 patients dead within one year of diagnosis. A 1982 University of Pittsburgh report of 21 cases[11] found a median survival of eight months, with only 32% of patients alive at an average interval of 27 months. A Harvard series of 20 cases[16] reported only 30% of patients alive NED after one to 12 years. Other studies have more hopeful findings. Burke et al[10] reported a series from M.D. Anderson in 1977 in which 35 patients with thyroid lymphoma obtained an overall five-year survival of 54%. Their technique employed "thyroid mantle" irradiation using ^{60}Co, in which an anterior field covering neck and mediastinum was treated with 40 Gy TD in four weeks, with a supplemental PA dose to the mediastinum. A recent study from Japan, which included 70 cases of malignant thyroid lymphoma, reported an overall five-year survival of 74%.[7] The degree of success in treating thyroid lymphomas has been quite variable between institutions.

Histologically, malignant lymphoma of the thyroid is predominantly DH. Two reports from M.D. Anderson[10,17] indicated "histiocytic" histology in 34 of 35 cases, or 32 of 38 being DH; one case was NPDL. Only one of 18 cases reviewed in a Harvard study was nodular; the other 17 were diffuse histologies.[16] Hamburger et al[18] similarly reported only one of 30 recent cases to be NPDL. The success in treating thyroid lymphoma in various reports, therefore, largely reflects the successful treatment of DH of the thyroid, not NPDL of the thyroid.

Compagno and Oertel suggest that the differential diagnosis of thyroid lymphoma includes advanced thyroiditis and small cell carcinoma.[4] Heimann et al reviewed cases previously classified as small cell carcinoma of the thyroid and suggested that all should be reclassified as thyroid lymphoma. They expressed doubt that small cell carcinoma of the thyroid was even real.[19] Carcangui et al, on the other hand, presented 25 cases of small cell carcinoma of the thyroid, which they regarded as distinct from lymphoma.[20]

The role of thyroiditis in the development of thyroid lymphoma is unclear. Grimley and Oates reported only four of 12 patients with thyroid lymphoma had associated Hashimoto's thyroiditis,[21] contradicting many other studies that indicate a strong association between thyroid lymphoma and chronic lymphoid thyroiditis. Compagno and Oertel[4] reported a strong association between the two entities. Anscombe and Wright[22] noted lymphocytic thyroiditis in all 39 cases in which there was enough residual thyroid tissue to make the assessment. Aozasa et al found chronic lymphocytic thyroiditis in 83% of their patients with thyroid lymphoma. Burke et al[10] found the condition in all 27 cases in which residual thyroid parenchyma remained.

Holm et al examined the incidence of malignant tumors and leukemia in 829 patients previously diagnosed as having chronic lymphocytic thyroiditis and 829 matched controls with colloid goiter.[23] There was a statistically significant increase in risk for myeloproliferative and lymphoproliferative neoplasms in general and also for malignant thyroid lymphoma in particular, suggesting that chronic lymphocytic thyroiditis may be a precursor to malignant thyroid lymphoma.

The prognosis for patients with thyroid lymphoma is also cause for disagreement among researchers. The "working formulation" described by Rosenberg et al[24] renamed the NPDL of Rappaport "follicular small cleaved cell" and classified it as low grade, implying an inherently favorable prognosis. Mizukami et al[25] reported four patients with follicular lymphomas in their series of 20 patients and found diffuse histology to be an unfavorable prognostic factor. Burke et al[10] reported four patients with some degree of nodularity in 35 patients with thyroid lymphoma; all survived five years.

Turning to larger populations, Lawrence et al[26] reported 54 patients with stage I-II indolent lymphomas at various sites. Forty-eight received various courses of XRT as some part of their treatment, and overall survival was 60% at 10 years. The disease-free survival rate, however, was only 48%.

Burton et al[27] reported 44 patients with low-grade extranodal stage I and II head and neck lymphomas, who had a disease-free survival rate of 57% after a median of 7.2 years. It should be noted that the "low-grade" or "favorable prognosis" designation of NPDL depends upon prior observations of survival at a time point of five years, and in comparison to the behavior of DH.

Estimates from institutions with large series of lymphoma patients, M.D. Anderson[28] and Stanford,[29] are that only 13%-15% of low-grade lymphomas will be pathological stage I-II. Heifetz et al[30] reported staging laparotomy was part of an extensive evaluation of patients with clinical stage I and II non-Hodgkin's lymphoma (NHL). Sixty-one percent of patients with nodular lymphoma were stage advanced at laparotomy whereas only 22.5% of diffuse lymphoma patients had such an outcome. Unsuspected involvement below the diaphragm in a patient treated only above the diaphragm by a local-regional modality should eventually lead to distant failure unless other cause of death would intervene. Lawrence et al[26] in their study of 54 stage I and II patients with indolent lymphomas found that patients treated only by chemotherapy failed locally whereas patients treated by XRT tended to fail in other lymph nodes. Spry et al[31] studied 88 patients with low-grade stage I and II lymphomas treated by XRT only; most failures were at distant sites.

Portlock[32] points out that "low," "intermediate," and "high grade" had prognostic significance based on 1975 survival curves, but that we are now curing greater than 50% of patients with "intermediate" or "high grade" NHL by aggressive treatment; this creates a plateau in the survival curves for these lymphomas which crosses the survival curve for "low-grade" NHL at approximately 5-6 years follow-up.

The addition of chemotherapy to XRT logically rests upon two points: 1) the foregoing information indicating a high probability of eventual failure following XRT alone for clinically staged I and II NPDL patients and 2) the existence of a chemotherapy regimen with a good probability for eradicating subclinical NPDL outside the XRT fields. Involved-field XRT plus combination chemotherapy has yielded high survival rates recently in various studies; for example, Connors et al[33] in high grade lymphomas. Recent reports from M.D. Anderson[28,34] indicate that combined-modality treatment of stage I and II "low-grade" lymphomas has yielded higher relapse-free survival rates, and a higher potentially cured fraction of patients than XRT alone.

An Israeli study of 48 stage I and II low-grade lymphoma patients treated in various ways and subjected to multivariate analysis showed the use of XRT in the initial treatment was the factor that most influenced better survival.[35] Vigliotti et al[17] have described XRT as 40 Gy in 20 fractions to a thyroid mantle covering the neck and mediastinum.[17] The Mayo Clinic and Princess Margaret Hospital groups have studied extent of XRT fields for thyroid lymphomas,[1,36] concluding that XRT covering both the neck and mediastinum is associated with better survival relative to XRT to the neck alone. Treatment of low-grade lymphomas to doses greater than 40 Gy apparently yields a 90% or greater probability of local control.[29]

The foregoing considerations led to our decision in favor of combined modality treatment of our otherwise generally healthy 44-year-old woman with clinical stage IE nodular, poorly differentiated lymphoma of the thyroid. Were we to have an 84-year-old female patient with the same disease and other major medical problems, we could have chosen a different management plan.

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INDEX TO VOLUME 89

A

A Physician's Prayer - Madduri, S D 270
Advance Directives: Beginning the Process - Sessions, Donald G 7
Advertisers Index
........63, 127, 193, 257, 317, 381, 453, 701, 761, 817, 872
Aggressive Rehabilitation Following Anterior Cruciate Reconstruction: An Update & Protocol - Pomphrey Jr, Martin 358
Arora, Ravinder, et al - Neurological Aspects of Acquired Immune Deficiency Syndrome (AIDS): A Clinical Review 169
Ash, Charles J, et al - The Use of Rectal Temperature to Monitor Heat Stroke 283
Auner, Cecil R, et al - The Use of Rectal Temperature to Monitor Heat Stroke 283
Auxiliary Message
........11, 79, 213, 277, 337, 411, 661, 719, 773

B

Bagby, John R, et al - Racial Differences in Cardiovascular Disease Mortality and Risk Factors 42
Baumgartner, Todd, et al - Human Immunodeficiency Virus (HIV) Seroprevalence Surveys 843
Because of You - Chapman, Nona Nan 661
Biery, Richard M, et al - Human Immunodeficiency Virus (HIV) Seroprevalence Surveys 843
Biliary Nightmare - Tucker, Leslie E 842
Bilirubin Encephalopathy in a Term Infant After Planned Home Delivery - Schroeder & O'Connor 741
Blueprint for Reform in Medical Education, A: The University of Missouri School of Medicine at the Turn of The Century - Stephenson, Evans 345
Bode, Eugene T , et al - Bronchopulmonary Lavage for Pulmonary Alveolar Proteinosis 27
Bohigian, George M - Humor is Good Medicine 679
Boullier, John, et al - Malignant Tumor of the Colon Metastatic to the Epididymis as a First Sign of Recurrence of Colon Cancer 298
Boyarsky, Rose, et al - Thanatology: A New Clinical Specialty to Help Confront Death 95
Boyarsky, Saul, et al - Thanatology: A New Clinical Specialty to Help Confront Death 95
Bradley, Richard V - Momedico: An Answer to a Need 85
Braun, Sheldon R, Shuttari, Mir F - Contemporary Management of Chronic Persistent Cough 795
Breast Conservation Therapy, The St. Luke's Hospital Experience - Garcia, Halverson 164
Bronchopulmonary Lavage for Pulmonary Alveolar Proteinosis - Tate, Zoellner, Bode 27
Brownson, Ross C, et al -
  Racial Differences in Cardiovascular Disease Mortality and Risk Factors 42
  The Missouri Cardiovascular Health Plan: A Focus on Prevention 362
Buebendorf, Norman D, et al - Skin Expansion as Preparation for an Opening Wedge Osteotomy of the Mid-Foot in Arthrogryposis 671
Burns, Thomas W, et al - Massive Gastric Hemorrhage Due to Small Vessel Erosion (The Dieulafoy Lesion) ..39
Butt, James H, et al - Massive Gastric Hemorrhage Due to Small Vessel Erosion (The Dieulafoy Lesion) 39

C

Carrier, John A - Pearl 208
CHAMPUS Guidelines for Missouri Physicians - Mills, Patrick, J 782
Change Can Bring Us Risk and Opportunity - Hunkeler, Mary 11
Change is inevitable - Hunkeler, Mary 213
Chapman, Nona Nan - Because of You 661
Chechani, Vijay - Invasive Pulmonary Aspergillosis Complicated by Nocardiosis in a Patient with Agnogenic Myeloid Metaplasia 98
Classified Advertisements
......61, 125, 191, 255, 315, 379, 450, 641, 699, 759, 814, 871
Clinic Will "Link" the Indigent Patient into the Existing Health Care System - Weiser, Dennis 217
Code of Medical Ethics & Fundamental Elements of the Patient-Physician Relationship 468
Codes for Self-Designation of Practice Specialties by Specialty 543
Component Medical Society Codes 506
Concannon, Matthew J, et al - Skin Expansion as Preparation for an Opening Wedge Osteotomy of the Mid-Foot in Arthrogryposis 671
Contemporary Management of Chronic Persistent Cough - Shuttari, Braun 795
Continuing Medical Education
........59, 123, 189, 253, 313, 377, 697, 757, 810, 868
Contracts - Williams, Carol F 657
Convention Committee Reports, 134th Annual 425
Convention Exhibitors 447
Convention Registration 436
Cover Art -
  Agnew, Al ....*February*
  Barnes, Jesse ....*November*
  Fries, John W ....*July*
  Martin, Terry L ....*January, March*
  Owens-Kummer, Medge D ....*October*
  O'dell, John ....*August, December*
  Piper, Donald K ....*April*
  Taylor, William J ....*May*

Shaw, Robert D .... *June*
Ting, Shirley Chao .... *September*
Cook, James R, et al - The Use of Rectal Temperature to Monitor Heat Stroke 283
Council Minutes Summary 1991-1992 441
Courtesy Resolution on Deceased Members 444
Craig, Judith, et al - HIV Seroprevalence Surverys 843
Cry of the Heart, Reflections of a practitioner - Dehner, Louis P 333

D

Dabney, Sue, et al - The Missouri Cardiovascular Health Plan: A Focus on Prevention 362
Define the Product Before Trying to Fix It - Williams, Carol F 331
Dehner, Louis P - Cry of the Heart, Reflections of a practitioner 333
Dermatology Quiz Answers 801, 857
Dermatology Quiz Questions 874, 819
Diagnosis and Management of Ulnar Nerve Entrapment - Gumucio, Lund, Young, Young 231
Disciplinary Actions 65, 215, 682, 805
Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor - Haghighi, York, Ebeling, Gumerlock, Oro, Gaines 790
Doisy, K E, et al - Research on Ticks and Tickborne Pathogens in Missouri, An Interim Research Report 339
Donnell Jr, Denny H - The Enigma of Lyme Disease in Missouri 714
Durham, Rodney, et al - Seat Belt Usuage by Trauma Center Personnel 102

E

Ebeling, John, et al - Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor 790
Editor's Desk
.... 7, 75, 139, 203, 267, 327, 651, 711, 771, 827
Enigma of Lyme Disease in Missouri, The - Donnell 714
Ercal, Nuran, et al - Nodular Poorly Differentiated Lymphocytic Lymphoma of the Thyroid 846
Esophageal Stricture: Results of Dilation of 300 Patients - Tucker 668
Evans, Maria L - **Residents' News**
Get Someone To Cover For Half An Hour 747
MSMA-RPS, What's in it for me? 685
Evans, Maria L, Springer, David - Residents' News, When the Bloom Is Off the Rose, What to do When the Residency of your Dreams Isn't 367
Evans, Maria L, Stephenson Jr, Hugh E - A Blueprint for Reform in Medical Education: The University of Missouri School of Medicine at The Turn of The Century 345
Ercal, Nuran, et al - Nodular Poorly Differentiated Lymphocytic Lymphoma of the Thyroid 846

F

Family Violence - Huffaker, Elizabeth 79
Family Violence - Kiekhaefer, Ruth 773
Food for Thought - Holzem 675
Fravell, Sharon, et al - Seat Belt Usuage by Trauma Center Personnel 102

G

Gaines, Robert W, et al -
Skin Expansion as Preparation for an Opening Wedge . Osteotomy of the Mid-Foot in Arthrogryposis 671
Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor 790
Gale, Arthur H -
Has the Missouri State Board of Registration for the Healing Arts Gone too Far 17
National Practitioner Data Bank: The Toy of The Imperial Congress - When Bad Things Happen to Good Doctors 720
Garcia, Delia M, et al -
Breast Conservation Therapy, The St. Luke's Hospital Experience 164
Selected Topics in Breast Conservation Therapy 731
Gerhardt, Donald C, et al -Massive Gastric Hemorrhage Due to Small Vessel Erosion (The Dieulafoy Lesion) .. 39
Gipson, Kevin S, et al - HIV Seroprevalence Surveys 843
Goldberg, Anne, et al - The Missouri Cardiovascular Health Plan: A Focus on Prevention 362
Goran, Mark H, et al - U.S. Department of Health and Human Services Issues Final Medicare and Medicaid Anti-kickback Safe Harbor Regulations 83
Gumerlock, Mary K, et al - Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor 790
Gumucio, Cesar A, et al - Diagnosis and Management of Ulnar Nerve Entrapment 231

H

Hagan III, John C -
A Prospective Study of the Transition to Phacoemulsification and Small Incision Cataract Surgery 663
Humor is Good Medicine, Vol 2 781
Personal Computing: Just Do It! 727
Haghighi, Siavash S, et al - Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an

Intramedullary Spinal Tumor 790
Hall, R D, et al - Research on Ticks and Tickborne Pathogens in Missouri, An Interim Research Report . 339
Halverson, Karen J, et al -
  Breast Conservation Therapy, The St. Luke's Hospital Experience 164
  Selected Topics in Breast Conservation Therapy ... 731
Has the Missouri State Board of Registration for the Healing Arts Gone too Far? - Gale, Arthur 17
Here Comes 1992 - Reister, Dorothy 9
Hoff, Gerald L, et al - HIV Seroprevalence Surveys .. 843
Holzem, Craig S - Food for Thought 675
Horton Jacqueline, et al - Racial Differences in Cardiovascular Disease Mortality and Risk Factors 42
Hewadikaram, K A, et al - Research on Ticks and Tickborne Pathogens in Missouri, An Interim Research Report 339
Huffaker, Elizabeth - Family Violence 79
Hugh E Stephenson Jr - Thomas, J Regan 771
Human Immunodeficiency Virus (HIV) Seroprevalence Surveys - Spare, Kenneth W, et al 843
Humor is Good Medicine - Bohigian 679
Humor is Good Medicine, Vol. 2 - Hagan 781
Humphrey, Paul, et al - Isolated Traumatic Accessory Splenic Rupture: A Case Report & Literature Review .. 351
Hunkeler, Mary - **Auxiliary Message**
  Change can bring us risk and opportunity 11
  Change is inevitable 213
  The Auxiliary Works With You 411

I

Importance of Feelings, The - John Stuart Munro 729
Infectious Waste Management Guidelines for Missouri Physicians - Mills, Patrick J 836
Information for Contributors
...... 63, 127, 193, 257, 317, 381, 453, 640, 701, 761, 817, 872
In Memoriam -
  January - Anderson, Arnold, Bauer, Curts, Ebel, Fleishman 25
  February - Cowan, Eggleston, Knight, Owen Jr, Taylor 109
  March - Feltz, Gronau, Simril, Washburn 177
  April - Bruner, Deutch, Dzundzev, Hummel, Klingner, Weinhaus, Yancey 241
  May - Allbee, Eller, Klein, Redmond, Seib, Utterman, Whitsell 301
  June - Burton, Gilpin, Johnston, Kuczer, MacInnis, Otto, Tashma, Walters 373
  July - Goldring, Harford, Keffler, Virant, Willoughby 449
  September - Campbell, Dickler, Fitzgerald, Hooper, Kienzle, Rothweiler, Siesener, Wilkinson 693
  October - Arms, Cohle, Heins, Mueller, Reimer, Yannakakis 753
  November - Antoniou, Fagan, Hagebusch, Schwartz, Wilson 809
  December - Arnold, Bortnick, Cope, Goodman, Jensen, Muschany 865
Insurance Options for MSMA Members 503
Intranasal Melanoma - Schroeder, Jr 294
Is the PRO a Quack? - Layle 89
Isolated Traumatic Accessory Splenic Rupture: A Case Report and Literature Review - Richmond, Humphrey, Nichols 351
Invasive Pulmonary Aspergillosis Complicated by Nocardiosis in a Patient with Agnogenic Myeloid Metaplasia - Chechani 98

K

Kayaking as a Risk Factor for Leptospirosis - Shaw, Robert D 354
Keegan, Mary, et al - Seat Belt Usuage by Trauma Center Personnel 102
Kiekhaefer, Ruth - Family Violence 773

L

LaFontaine, Tom, et al - The Missouri Cardiovascular Health Plan: A Focus on Prevention 362
Layle, John - Is the PRO a Quack? 89
Legal Challenges to Denials of Insurance Coverage for "Experimental" Medical Treatments - Testerman, Michael R - 222
Letters to the Editor -
  Werner, Davis, Saghir - *January* 15
  Hoeper Sr, Patel - *February* 129
  Witt, Miller, Wilson et al, Whittaker, Westhoff, McKinney - *March* 141
  Whittaker, Sisson - *April* 205
  Dixon, Tomlinson - *May* 269
  Masters, Tromans, - *June* 329
  Masters, Feir, DeBoard, Glass Jr, - *September* 653
  Dennis, Hall, - *October* 713
  Mills, Groshong - *November* 777
  Cashman, Weiss - *December* 833
Liability Epidemic - Health Care Costs: Break the Linkage - Norland, Charles C 226
Lund, Herluf, et al - Diagnosis and Management of Ulnar Nerve Entrapment 231

M

McDonald, G A, et al - Research on Ticks and Tickborne Pathogens in Missouri, An Interim Research Report . 339
Madduri, S D - poetry
  A Physician's Prayer 270
  Romancing the Stone 686
Malignant Tumor of the Colon Metastatic to the Epididymis as a First Sign of Recurrence of Colon Cancer -

Parra, Boullier, Mehan 298
Massive Gastric Hemorrhage due to Small Vessel Erosion (The Dieulafoy Lesion) - Burns, Stephenson, Butt, Gerhardt 39
Matching doctors with their futures 303
Matthews, R H, Ercal, N - Nodular Poorly Differentiated Lymphocytic Lymphoma of the Thyroid 846
Medical School News
..... 55, 119, 186, 250, 310, 374, 694, 754, 810, 866
Medical Specialty Organizations, Directory of 495
Medicare Poster 221
Mehan, Donald J, et al - Malignant Tumor of the Colon Metastatic to the Epididymis as a First Sign of Recurrence of Colon Cancer 298
Membership Roster -
  Alphabetized 506
  Component Society 570
  Primary Specialties 544
  Students 638
McMurry, Ted A, et al - The Use of Rectal Temperature to Monitor Heat Stroke 283
Mills, Patrick J -
  CHAMPUS Guidelines for Missouri Physicians ... 782
  Infectious Waste Management Guidelines for Missouri Physicians 836
Minutes of the House of Delegates, 134th MSMA Annual Convention 393
Missouri Cardiovascular Health Plan, The: A Focus on Prevention - Dabney, Smith, Brownson, Goldberg, LaFontaine 362
Missouri Physicians' Health Committee 460
MMPAC Sustaining Members 1992 487
Momedico: An Answer to a Need - Bradley 85
Moore Jr, John E - The Right Medicine 267
". . . More on this story and tape at 10" - Thomas 203
Moore- Nichols, Judith, et al - HIV Seroprevalence Surveys 843
MSMA -
  Districts, Councilors, Societies (code #), Counties, Directory of 505
  Committees & Commissions 493
  Component Societies Executives 499
  Constitution & Bylaws 477
  Financial Statement - 1991 158
  Foundation Financial Statement - 1991 162
  Officers, Councilors, Vice Councilors, AMA Delegates, AMA Alternate Delegates, (photos) 463
  Policy Manual 471
  Preliminary Convention Program 149
MSMA-RPS, What's in it for me? - Evans, Maria 685
MSMF Annual Meeting 446
Munro, John Stuart - The Importance of Feelings 729
Murrell, Beverly - Doctor, Can you spare some time? .. 719

N

NPDB: When Bad Things Happen to Good Doctors - Gale, Arthur H 720
Neurological Aspects of Acquired Immune Deficiency Syndrome (AIDS): A Clinical Review, The - Arora, Sahota 169
New Opportunities - Editor's Desk - Thomas 139
Nichols, W Kirt, et al - Isolated Traumatic Accessory Splenic Rupture: A Case Report & Literature Review 351
Nodular Poorly Differentiated Lymphocytic Lymphoma of the Thyroid - Matthews, Nuran 846
North, Carol S, et al - Thanatology: A New Clinical Specialty to Help Confront Death 95
Norland, Charles C - Liability Epidemic - Health Care Costs: Break the linkage 226

O

Ombudsman's Update - Patrick J Mills
  CHAMPUS Guidelines 782
  Infectious Waste Management Guidelines 836
O'Connor, Timothy A, et al - Bilirubin Enchephalopathy in a Term Infant After Planned Home Delivery 741
Oro, John J, et al - Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor 790

P

Parra, Raul O, et al - Malignant Tumor of the Colon Metastatic to the Epidiymis as a First Sign of Recurrence of Colon Caner 298
Pearl - Carrier 208
Pearce, Eugene W J - photograph 118
Perez, Carlos A, et al - Selected Topics in Breast Conservation Therapy 731
Perkins, David E - Marge Perkins, The 1992-1993 Auxiliary President 277
Perkins, Marge - Auxiliary Message, Acceptance Speech MSMAA Convention 337
Personal Computing: Just Do It! - Hagan III, John C . 727
Phacoemulsification and Small Incision Cataract Surgery, A Prospective Study of the Transition to - Hagan 663
Phillips, Michael R, et al - Transfusion Medicine in the '90s, Why it has changed and how 785
Pittman, C Christopher - Student Loans and Moonlighting, Resident Section News 113
Pittman, David C, et al - Transfusion Medicine in the '90s, Why it has changed and how 785
Physician Extenders - Williams, Carol F 835
Physicians' Charity Care Program Update 129
Physicians' Recognition Award
..... 47, 94, 247, 307, 371, 681, 743, 803, 859

Political Action Committee Members 1992 ....485, 487
Pomphrey Jr, Martin M - Aggressive Rehabilitation Following Anterior Cruciate Reconstruction: An Update and Protocol 358
Practice Management - Woerth, Janice K 13, 81, 147, 211, 275, 335, 659, 745, 775, 831
Presidential Inauguration Speech - Williams, Carol ..403
President's Page 9, 77, 143, 271, 331, 403, 407, 657, 717, 835
Prospective Study of the Transition to
Puckett, Charles L, et al - Skin Expansion as Preparation for an Opening Wedge Osteotomy of the Mid-Foot in Arthrogryposis 671

R

Racial Differences in Cardiovascular Disease Mortality and Risk Factors - Brownson, Smith, Horton, Bagby ...43
Recent Trends in the Selection and Fitting of Hearing Aids - Valente Michael, Skinner, Valente Maureen ...104
Renewal Fee - The Cost of your License as a Professional - Tromans 19
Research on Ticks and Tickborne Pathogens in Missouri, An Interim Research Report - Hall, Hewadikaram, McDonald, Doisy 339
Residents Section News 46, 113, 179, 243, 303, 367, 685, 747
Reister, Dorothy D - **President's Page**
  Here Comes 1992 9
  Unite and Win 207
  United We Stand 407
  We Must Be Involved in the Decisions That Will Determine Medicine's Role in Society 77
  What is a Responsible Physician? 143
Resolutions of the 134th House of Delegates 414
Richmond, Ron, et al - Isolated Traumatic Accessory Splenic Rupture: A Case Report & Literature Review351
Right Medicine, The - Moore Jr - Guest Editorial 267
Role of Antibiotics in the Management of Acute Exacerbation of Chronic Bronchitis, The - Skudlarska, Scott 289
Romancing the Stone - Madduri, S D 686

S

Sahota, P K, et al - Neurological Aspects of Acquired Immune Deficiency Syndrome (AIDS): A Clinical Review, The 169
Schroeder, Lisa L, et al - Bilirubin Encephalopathy in a Term Infant After Planned Home Delivery 741
Schroeder Jr, Walter A - Intranasal Melanoma 294
Scott, Graham C, et al - The Role of Antibiotics in the Management of Acute Exacerbation of Chronic Bronchitis 289
Seat Belt Usuage by Trauma Center Personnel - Shapiro, Fravell, Durham, Keegan 102
Selected Topics in Breast Conservation Therapy - Halverson, Garcia, Taylor, Perez 731
Sessions, Donald G - The Wall 779
Sessions, Donald G - **Editor's Desk**
  Advance Directives: Beginning the Process 7
  Will We Be All Right? 75
Shapiro, Marc J, et al - Seat Belt Usuage by Trauma Center Personnel 102
Shaw, Robert D - Kayaking as a Risk Factor for Leptospirosis 354
Shuttari, Mir F, et al - Contemporary Management of Chronic Persistent Cough 795
Skin Expansion as Preparation for an Opening Wedge Osteotomy of the Mid-Foot in Arthrogryposis - Buebendorf, Concannon, Gaines, Puckett 671
Skinner, Margaret W, et al - Recent Trends in the Selection and Fitting of Hearing Aids 104
Skudlarska, Beata A, et al - The Role of Antibiotics in the Management of Acute Exacerbation of Chronic Bronchitis 289
Smith, Carol A, et al -
  Racial Differences in Cardiovascular Disease Mortality and Risk Factors 42
  The Missouri Cardiovascular Health Plan: A Focus on Prevention 362
Spare, Kenneth W, et al - HIV Seroprevalence Surveys 843
Springer, David et al - Residents' News, When the Bloom Is Off the Rose, What to do When the Residency of your Dreams Isn't 367
State Map with District and Component Societies Boundaries 504
Stephenson Jr, Hugh E - What is a residency? 243
Stephenson Jr, Hugh E, et al -
Massive Gastric Hemorrhage Due to Small Vessel Erosion (The Dieulafoy Lesion) 39
Stephenson Jr, Hugh E, Evans, Maria L - A Blueprint for Reform in Medical Education: The University of Missouri School of Medicine at The Turn of The Century 345
Super PAC Members 1992 485

T

Taking the Guesswork Out of Bloodborne Pathogen Regulations - Thomas, J Regan 327
Tate, Kara, et al - Bronchopulmonary Lavage for Pulmonary Alveolar Proteinosis 27
Taylor, Marie E, et al - Selected Topics in Breast Conservation Therapy 731
Testerman, Michael R - Legal challenges to denials of insurance coverage for "experimental" medical treatments 222
Thanatology: A New Clinical Specialty to Help Confront Death - Boyarsky S, North, Boyarsky R, ...95
The Wall - Sessions, Donald G 779
This (insignia), Not This! - Wooldridge, Wilfred E 711

Tick and Tickborne Pathogens in Missouri, Research on, An Interim Research Report - Hall, Hewadikaram, McDonald, Doisy 339
Thomas, J. Regan - **Editor's Desk**
  New Opportunities 139
  ". . . More on this story, and tape at 10." 203
  You Have Our Address 651
  Hugh E Stephenson Jr., MD 771
Tromans, Frederick A - Renewal Fee - The Cost of your License as a Professional 19
Tucker, Leslie E -
  Esophageal Stricture: Results of Dilation of 300 Patients 668
  Biliary Nightmare 842

U

Unite and Win - Reister 207
U.S. Department of Health and Human Services issues final Medicare and Medicaid anti-kickback safe harbor regulations - Wiehl & Goran 83
University of Missouri School of Medicine at The Turn of The Century, A Blue Print for Reform in Medical Education - Stephenson Jr, Evans 345
Use of Rectal Temperature to Monitor Heat Stroke, The - Ash, Cook, McMurry, Auner 283

V

Valente, Michael, et al - Recent Trends in the Selection and Fitting of Hearing Aids 104
Victory in the Gulf War 118
View from the Window, A - Williams, Carol 271

W

Walker, Kent D - Dermatology Quiz 801-819, 857-874
Weiser, Dennis L - Clinic will "link" the indigent patient into the existing health care system 217
What is a residency? - Stephenson Jr, Hugh E 243
What is a Responsible Physician? - Reister, Dorothy . 143
When bad things happen to good doctors, NPDB - Gale, Arthur H 720
When the Bloom Is Off the Rose, What to do when the residency of your dreams isn't - Springer, David, Evans, Maria 367
Wiehl, James G, et al - U.S. Department of Health and Human Services Issues Final Medicare and Medicaid Anti-kickback Safe Harbor Regulations 83
Will We Be All Right? - Sessions, Donald G 75
Williams, Carol - **President's Page**
  Contracts 657
  Define the Product Before Trying to Fix It 331
  Physician Extenders 835
  Plugging the Gaps in Health Care 717
  Seeking Medicine's Good 403
  View from the Window, A 271
Woerth, Janice K - **Practice Management**
  .... 13, 81, 147, 275, 335, 659, 745, 775, 831
Wooldridge, Wilfred E - This! Not this! 711

Y

York, Donald H, et al - Dissociation of Somatosensory and Motor Evoked Potentials in a Patient with an Intramedullary Spinal Tumor 790
You Have Our Address - Thomas, J. Regan 651
Young, Ann E, et al - Diagnosis and Management of Ulnar Nerve Entrapment 231
Young, Leroy V, et al - Diagnosis and Management of Ulnar Nerve Entrapment 231

Z

Zoellner, Patrick, et al - Bronchopulmonary Lavage for Pulmonary Alveolar Proteinosis 27

New Members

January 49
Barnhouse, Joseph R, Bartell, Michael F, Bird, Jonathon M, Birnbaum, Elisa H, Botney, Kathryn, Braverman, Alan C, Camp, Alan D, Cavanaugh, Timothy B, Colon, Luis E, Crapotta, Joseph A, Creech, Fred T, Crotty, John P, Cruz, Christopher T, DelPriore, Lucian V, Demmy, Todd L, Downs, Mary K, Epstein, Jay S, Fracasso, Paula M, Francel, Thomas J, Gillbanks, Marjon M, Gray, Diana L, Hendrickson, Barry L, Huddleston, Charles B, Hutchins, Sherry S, Jibben, Bobby J, Jones, Timothy R, Jotte, Randall S, Kakaiya, Ram M, Kim, Harold E, Kwoun, Soung O, Lehman, richard C, Marcus, Michael D, McCroy, James H, Miller, Dace L, Park, Tae S, Parks, William C, Pavelonis, Joe D, Rubin, Bruce K, Sabatino, Anthony, Schlehr, Frank J, Scodary, Daniel, Scroggins, Larry, Silverstein, Steven M, Slimack, Joseph P, Smith, Toni R, Somers, Michael E, Soucie, Carol J, Steigman, Carmen K, Stepp, Timothy E, Sutphen, Eric J, Tarantino, Celeste A, Tate, Kara L, Tenorio, Gene, Tredwell, Randell E, Trowbridge, Denise R, Tyler, Thomas D, Vietti, Teresa J, Vo, Thuy-Lieu T, Vollmer, Dennis G, Wadsworth, Harry, Weaver, Mark E, Williams, Charlie B, Wyatt, Ronald M.

Resident Section:
Anglo, Luis J, Babar, Salma S, Bhat, Sanjay T, Birmingham, Jean E, Bitar, Saad R, Boesch, Jeffrey L, Bohn, Sara A, Brown, David M, Cayabyab, Lilibeth M, Creswell, Lawrence L, Cumadag-Sabio, Maria C, Garola, Robert E, Hosley, Brett D, Jamry, Wit A, Keleti, Daniel, Meyer, Joseph B, Mink, Johnathan W, Peplinski, Gary R, Pineda Juan J, Ramirex, Raymunde E, Romeo, Joseph P, Saha, Debabrata, Scariano, Lawrence A, Sky, Adam J, Springer, David D, Stamps, Ruanne M, Stevens, Tracy L, Teague, Brettly J, Tsen, Tony N, Tsolakoglou, Cleo, Uketui, Ozemenam I, Wait, Erik J, Wright Jr, William P.

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February 115
Alis, Susy, Appelbaum, James S, Black, David L, Blinder, Kevin J, Callicoat Jr, Paul E, Chow, Susanne M, Coleman, Terrence W, Conrace, Joseph E, Crighton, Kent A, Curran, Donald J, Diemer, Jean, Diemer, Thomas S, Dillard, Sandy R, Dunn, David B, Dunn Melanie A, Edwards, Shelly J, Arwell, James L, Hoja, John M, Johnson, Jonathon H, Johnson, Rebecca S, Lakusiewicz, Ronald J, Lewis, David M, Libel, Roy D, Little, Patrick T, Massey, Vickie L, Melew, Mark, Patty, John R, Remo Jr, Jose A, Royce, Debra L, Scott, Joni C, Sherrod, Charles F, Smith, Ricky A, Somers, Michael E, Stringer, Robert F, Suthoff, Jim, Valuck, Richard P.

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Student Section:

Hinrichs, Christian S, Keller, Mary E, Kim, Mike C, Nichols, Kelly N, Thompson, Virginia A, Trump, Nichol M.

March 181
Alderman, Lillian C, Benz, Stephen M, Brown, Cynthia L, Caldwell, Fred M, Cook, Paul R, Danganan, Manuel S, Frevert, Larry F, Goldberg, John M, Hausam, Robert R, Scott, Andrew R, Yates, John M.

Resident Section:

Flores, Eduardo D, Gibb, Randall K, Henry, Kurt A, Limmer, Bryon L, Neblock, Tammy K, Prstojevich, Steven J, Rayford, Walter, Schroeder, Robert E, Stell, Juliette A.

April 245
Assil, Kerry K, Becker, William L, Boyd, James H, Crane, James P, Hagemann, Margarethe, Higgs, Philip E, Iyer, Manny S, Johnson Garry A, Koenig, Gary D, Kramer, Robert S, Lass, Anne N, Madlang, Rudy G, Onder, Robert F, Pinkham, Chris M, Randolph Jr, Bernard C, Rubin, Brian G, Steiner, Marvin P, Stewart, James G, Stuphen, Eric J, Tsai, Cheng Chang.

Resident Section:

Stiffman, Michael N, Walker, Kent D.

Students:

Charnond, Siroth, Cheng, Jacqueline T, Farrar, Cynthia D, Kim, Hee-Sun, Malhotra, Ranjan.

May 305
Ailor, Susan K, Anderson, Daphne K, Arbaugh, Scott J, Bowenschulte, Bradley A, Brocksmith, James T, Cassels Jr, John W, Evans, George A, Garcia, Kathleen M, Hicks IV, Robb R, Jaax, Jeffrey D, Kolda, Michael A, Scott, Michael R, Kuldeep, Singh, Turner, Marc A, Turner, Scott A, Walden Jr, James M.

Resident Section:

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June 369
Bluestone, Kenneth I, Bredemann, Jeffrey A, Callegari, Paul R, Gall, Clifford M, Godwin, Lehman W, Lawrence Jr, Willie E, Lobdell, Creig M, Matthews, J Mark, Mrosak, Daniel R, Powell, Cynthia K, Stone, Kenneth D, Stunk, Robert C, Wagman, Armin J.

Resident Section:

Colyer, Jeffrey W, Kory, Steven M, Nashelsky, Marcus, Tariq, Manzoor A, Yieng-Chu Su, Charles.

Student Section:

Horn, William C, McEnaney, Sean A, Rottnek, Fred W, Bennett, David, Bongu, Anurekha, Chandramohan, Kaladevi, Elliott, Jennifer A, Justesen, Anthony R, Karmazin, Alexander, Krishna, Priya, Madan, Sunil, Reddy, Sri, Silvius, January E.

September 687
Adams, W Stuart, Adams, Susan R, Aydelott, George A, Anderson, David J, Bock, David B, Branch, Walter D, Carothers, Karmel L, Davuluri, Sreenadha R, Daskalov, Zhivko, Devins, Sidney S, Downs, Craig E, Early, Gerald L, Gibson, William P, Guernsey, Kendra J, Hartley II, Robert D, Hess, Leonard W, Hughes, Douglas W, Hsu, Cecilia C, Johnson, Glen E, Johnson, Vincent G, Joyce, Jeffrey T, Kerley, Spencer W, Kinney, Janet S, Kossoy, Kent I, Mackinnon, Susan E, McCullough, Joseph E, McMurry, Ted A, Moor, Sidi Y, Pal, Michelle L, Rasmussen, Keith G, Roberts, Rebecca L, Roberts, Shauna R, Romaker, Ann M, Shaheen, Eleanor, Silen, Mark L, Stoops, Stephen L, Susi, Jesse G, Trombold, Walter S.

Resident Section:

Anderson, Karen L, Batchu, Sudhir S, Brady, Jane R, Carter, Jodianne T, Cusick, J Douglas, Eck, Kevin R, Gross, Gilda A, Hillyer, Jon F, Imlay, Ralph C, Kennedy, Charlotte J, King, Maurice L, Lachowsky, Francis F, Mani, Mary E, Page, Sammy L, Pauls, William S, Smith, Victoria L, Strimling, Robert B, Sutton, V Reid, Thruman, Jerome E, Tze, Anthony A, Whalen, Thomas R, Zelazny, Anthony M, Zobel, Mark S.

Student Section:

Chua, Heidi K, Ferdman, Barbara R, Guenther, Jane E, LaBarge, Jennifer A, Le Fevre, Cherie A, Luckett, Marc A, Mank, Jerome J, Maurizi, Michael G, Miles, John D, Mruzik, John C, Phillips, Michael, Prince, Joseph E, Richmond, Anthony G, Steffen, Donna M, Stuebben, Paula, Tuteur, Jennifer M, Willis, Deanna R.

October 749
Beal, Douglas W, Bieniek, Christopher M, Bocchini, Thomas P, Braverman, Stuart J, Caciolo, Barbara A, Coulter, Steven L, Fletcher Jr, James L., Gerdes, John M, Glass, James M, Grieshop, Theodore J, Himes, Joe E, Jessup, Michael J, Johnson, Patrick E, Kincaid, William L, Lemery, Robert, McGoff-Fahrner, Mari A, Madden, Michael L, Mirly, Harvey L, Neely, John G, Nielsen, Mary L, Peterson, Stephen E, Reed, Timothy F.

Resident Section:

Buergler, John M, Itoku, Kendall A, Koby, Myles B, Quesada, Eduardo W.

StudentSection:

Blackwelder, Lauren, Bomar, Sally A, Brown, Sharla M, Bryant, William C, Carron, Stephanie, Cope, Candise, Coy, Daniel J, Harrell, Darlicia, Henley, Jill, Hibbard, Robert B, Holland, Sara, Kelley, Rebecca, Kropf, David A, Lane, Joel R, McKinsey, Joel P, Miller, Timothy M, Norton, Oscar D, Nottmeier, Eric W, Olson, David R, Pereira, Susan, Reardon, Mary C, Siegel, Jeffrey, Sievert, Laura, Stranc, Danielle S, Tucker, Steven, Whitt, Stevan P.

November 806
Andrews, Christopher R, Anglen, Jeffrey O, Birchansky, Bonnie-Lee, Eldenburg, Steven C, Finley, John M, Goldberg, Joseph P, Halberstadt, Cathanie W, Haudrich, Stephen J, Hays, James E, James, Paul M, Jimenez, David E, Komes, Kevin D, LaFrancis, Irving E, Lawson, Noel W, Nichols, Margaret E, Reeves, R Bradley, Riley, Joel Y, Smith, Howard L, Swank, Darrell, Veitch, John M, Wheeler II, Frederick R, Wright, James C, Yahnke, David G, Zwerenz, Rose J.

Resident Section:

Bick, Linda G, Stansfield, Julie Ann D.

Student Section:

Combellick, Jacqueline D.

December 861
Allphin, Allan L, Bass, Elliot L, Berry, Danny T, Cheung, K Charles, Cokingtin, Dianna L, Dunn, Charles W, Ensley, Nancy J, Fahrner, Mari A, Fischi, Henry J, Gillbanks, Marjon, Hopson, David K, Hughes, Douglas W, Jetmore, Allen B, Looney, Steven C, Orr, Robert M, Paff, David G, Perryman, Douglas R, Rainbolt, Charles D, Sabates, Nelson R, Sheth, Hemant K, Staten, Stephen F, Vandergraaf, Robert C, Wallace, Elizabeth H, Westfall, Scott G, Weygandt, Paul L, Wiggins Stanley D, Wirths, Kimberly M, Wyatt, Douglas B, Zwibelman, Jay S.

Test your diagnostic skill by turning to the case report printed on the inside back cover. Make your diagnosis from the information printed on that page.

STOP!

ANSWER TO DERMATOLOGY QUIZ (No. 2)

by Kent D. Walker, MD and Philip C. Anderson, MD

The correct answer is:
***Loxosceles reclusa* bite.**

This case presents some of the many and extraordinary pitfalls in the early recognition and management of spider bites. The bite site of *L. reclusa* may not become painful until sometime (2 - 8 hours) after the envenomation. The patient may be systemically ill, but the site may appear to be a tender bruise, or not even noticed at all. Because of the painlessness of the bite, patients do not usually notice envenomation by the recluse spider. These factors may make early recognition of loxoscelism difficult and prevent the physician from finding the most important complication of the loxosceles bite, intravascular hemolysis, which can lead to renal failure and disseminated intravascular coagulation.

The brown recluse spider (*L. reclusa*) is very common in the midwest and south central U.S. This arachnid's body is 3 to 4cm in diameter, but with legs included it may reach 10 to 12mm in length. Violin-shaped cephalothorax markings suggest the name, "fiddle-back" spider. In colder climates the spider is likely to be found indoors, living in proximity to humans. They like quiet areas, attics, storage bins, and humans are at most risk when they disturb habitat. The venom is a tissue toxin which results in focal necrosis. The spider is not powerful enough to bite human skin unless it has clothing or bedding against which to stabilize itself. Once bitten, the skin displays transit erythema and possibly a small vesicle surrounded by ecchymosis. Ischemia develops, the bite site will become depressed and eventually an eschar will form. This eschar will then fall off to leave an ulcer. Prominent early generalized erythema, as seen in our patient, is common. Systemic involvement is more rare than focal necrosis, and tends to be associated with larger envenomations. Children are at the most risk of severe hemolysis and renal failure. A decline of hemoglobin from 14gm/dl to 4gm/dl over 6 to 12 hours has occurred in at least three cases of loxoscelism.

Other causes of focal necrosis should be considered: infection is the most important and vasculitis, or injections. Most patients do not require hospitalization provided there is no evidence of hemolysis. Wound care with cool soaks, topical antibacterial ointment and rest is generally all that is required. Use of a systemic corticosteroid is of questionable benefit in most cases, but may be helpful to the patient with widespread, toxic erythema. These wounds rarely become infected and systemic antibiotics are not usually required. Tetanus prophylaxis is recommended. Dapsone has no proven value, and early surgical intervention is harmful. These wounds heal well with time, but extremely large wounds may need graft coverage at 6 to 10 weeks.

Our patient was given systemic prednisone for one week, which offered improvement of the rash and malaise, but did not affect the bite itself. The wound healed well with a stellate scar over a six week period.

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Dermatology Quiz is coordinated by
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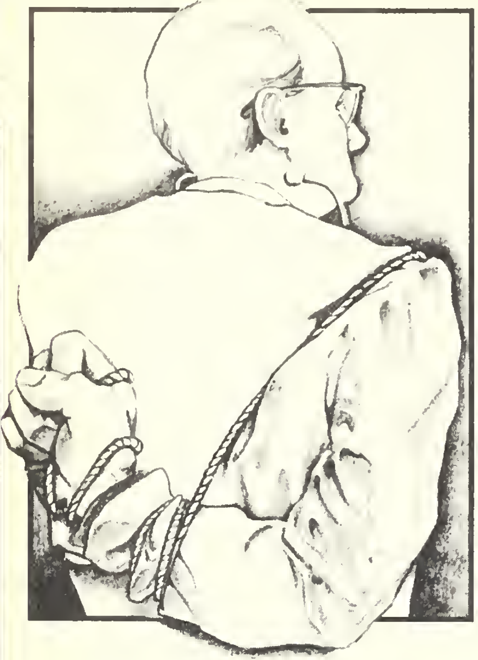
Department of Dermatology
University of Missouri Hospital and Clinics
One Hospital Drive, M173
Columbia, Missouri



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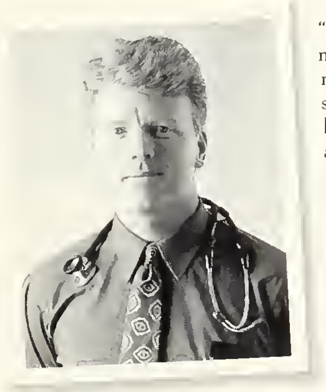

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❖ **Allan L. Allphin, M.D.,** 1965 S. Fremont, Suite 1950, Springfield, MO 65804, has become a member of the Greene County Medical Society. Dr. Allphin received his medical degree at Texas Tech University Health Sciences Center School of Medicine, Lubbock, TX. He completed his residency at Case Western Reserve University, Cleveland, OH. Dr. Allphin specializes in otolaryngology, head & neck surgery.

❖ **Elliott L. Bass, M.D.,** 2301 Main, Kansas City, MO 64108, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Bass received his medical degree at the University of Kansas School of Medicine, Lawrence, KS, in 1980. He completed his residency at the University of Kansas. Dr. Bass specializes in family practice.

❖ **Danny T. Berry, M.D.,** Emergency Medicine, Southeast Hospital, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Medical Society. Dr. Berry received his medical degree at the University of Arkansas, Little Rock, AR, in 1977. He completed his residency at St. Bernards, Jonesboro, AR. Dr. Berry specializes in emergency medicine.

❖ **K. Charles Cheung, M.D.,** 35 Doctors' Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Medical Society. Dr. Cheung received his medical degree at the University of Hawaii, Honolulu, HI, in 1977. He completed his residency at St. Louis University Medical Center. Dr. Cheung specializes in neurosurgery.

❖ **Dianna L. Cokingtin, M.D.,** 9406 E. 63rd St., Raytown, MO 64133, has become a member of Metropolitan Medical Society of Greater Kansas City. Dr. Cokington received her medical degree at the University of Missouri-Kansas City, in 1985. She completed her residency at The Children's Mercy Hospital and fellowship at the Medical College of Wisconsin, Milwaukee, WI. Dr. Cokington specializes in pediatrics.

❖ **Charles W. Dunn, M.D.,** 1900 S. National Ave., 2300W, Springfield, MO 65804, has become a member of the Greene County Medical Society. Dr. Dunn received his medical degree at Tulane Medical School, New Orleans, LA, in 1984. He completed his residency at Parkland Hospital, Dallas, TX. Dr. Dunn specializes in general surgery.

❖ **Nancy J. Ensley, M.D.,** 2401 Gillham Rd., Kansas City, MO 64108, has become a member of Metropolitan Medical Society of Greater Kansas City. Dr. Ensley received her medical degree at the Medical College of Virginia, Richmond, VA, in 1984. She completed her residency at the University of Washington, Seattle, WA. Dr. Ensley specializes in pediatric orthopedics.

❖ **Mari A. Fahrner, M.D.,** 226 S. Woods Mill Rd., Chesterfield, MO 63017, has become a member of the St. Louis Metropolitan Medical Society. Dr. Fahrner received her medical degree at the University of Alabama, Birmingham, AL, in 1985. She completed her residency at Barnes Hospital. Dr. Fahrner specializes in general surgery.

❖ **Henry J. Fischl, M.D.,** 1012 N. Main St., Sikeston, MO 63801, has become a member of the SEMO Medical Society. Dr. Fischl received his degree at St. Louis University School of Medicine in 1964. He completed his residency at St. Joseph Hospital, Memphis, TN. Dr. Fischi specializes in obstetrics/gynecology.

❖ **Marjon Gillbanks, M.D.,** Suite 709, 1515 W. Truman Rd., Independence, MO, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Gillbanks received his medical degree at Loyola University Stritch School of Medicine, Maywood, IL, in 1986. He completed his residency at Lutheran General Hospital, Parkridge, IL. Dr. Gillbanks specializes in internal medicine.

❖ **David K. Hopson, M.D.,** 2040 Loncourse Dr., St. Louis, MO 63146, has become a member of the St. Louis Metropolitan Medical Society. Dr. Hopson received his medical degree at Washington University, St. Louis, MO, in 1985. He completed his residency at Barnes Hospital. Dr. Hospson specializes in pathology.

❖ **Douglas W. Hughes, M.D.,** 8900 Indian Creek Pkwy, #450, Overland Park, KS 66210, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Hughes received his medical degree at the University of Oklahoma, Oklahoma City, OK, in 1988. He completed his residency at the University of Kansas Medical Center, Kansas City, KS. Dr. Hughes specializes in radiology.

❖ **Allen B. Jetmore, M.D.,** Suite 320, 4320 Wornall Rd., Kansas City, MO 64111, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Jetmore received his medical degree at Duke University, Durham, NC, in 1984. Dr. Jetmore specializes in colon/rectal surgery.

❖ **Steven C. Looney, M.D.,** 801 Faron, St. Joseph, MO 64501, has become a member of the Buchanan County Medical Society. Dr. Looney received his medical degree at the University of Missouri-Kansas City, in 1985. He completed his residency and fellowship at the University of Northwestern Memorial, Chicago, IL. Dr. Looney specializes in diagnostic radiology.

❖ **Robert M. Orr, M.D.,** 1001 E. 101st Terr., Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Orr received his medical degree at the University of Missouri-Columbia in 1983. He completed his residency at the University of Missouri-Columbia. Dr. Orr specializes in anesthesiology.

❖ **David G. Paff, M.D.,** 3231 S. National Ave., Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Paff received his medical degree at the University of Oregon, Portland, OR, in 1965. He completed his residency at the Kettering Laboratory, University of Cincinnati, Cincinnati, OH. Dr. Paff specializes in occupational medicine.

❖ **Douglas R. Perryman, M.D.,** 4400 Broadway #309, Kansas City, MO 64111, has become a member of Metropolitan Medical Society of Greater Kansas City. Dr. Perryman received his medical degree at the University of Oklahoma, Oklahoma City, OK, in 1988. He completed his residency at St. Lukes Hospital, Kansas City, MO. Dr. Perryman specializes in obstetrics/gynecology.

❖ **Charles D. Rainbolt, D.O.,** 301 W. Liberty, Farmington, MO 63640, has become a member of the Mineral Area Medical Society. Dr. Rainbolt received his doctor of osteopathy at the University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, in 1983. He completed his residency at the Naval Hospital, Pensacola, FL. Dr. Rainbolt specializes in family practice.

❖ **Nelson R. Sabates, M.D.,** Suite 300, 6650 Troost, Kansas City, MO 64131, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Sabates received his medical degree at the University of Missouri-Kansas City, in 1986. He completed his residency at the University of Oklahoma. Dr. Sabates specializes in ophthalmology.

❖ **Hemant K. Sheth, M.D.,** 3715 Beck Rd., Bldg. F, St. Joseph, MO 64506, has become a member of the Buchanan County Medical Society. Dr. Sheth received his medical degree at Seth G.S. Medical College, University of Bombay, Bombay, India, in 1979. He completed his residency at VAMC, Wilkes-Barre, Hahnemann University. Dr. Sheth specializes in internal medicine/pulmonary medicine.

❖ **Stephen F. Staten, M.D.,** 6313 Michigan, St. Louis, MO, 63111, has become a member of the St. Louis Metropolitan Medical Society. Dr. Staten received his medical degree at the University of Illinois, Chicago, IL, in 1983. He completed his residency at St. John's Mercy Medical Center. Dr. Staten specializes in family practice.

❖ **Robert C. Vandergraaf, D.O.,** 37 Doctors' Park, P.O. Box 1777, Cape Girardeau, MO 63702, has become a member of the Cape Girardeau County Area Medical Society. Dr. Vandergraaf received his doctor of osteopathy at Kirksville College of Osteopathic Medicine, Kirksville, MO, in 1983. He completed his residency at Fort Sam, Houston, TX. Dr. Vandergraaf specializes in anesthesiology.

❖ **Elizabeth H. Wallace, M.D.,** 8511 Hillcrest, Suite 820, Kansas City, MO 64138, has become a member of the Missouri State Medical Association. Dr. Wallace received her medical degree at Bowman Gray School of Medicine, Winston-Salem, NC, in 1986. She completed her residency at William Beaumont Army Medical Center, El Paso, TX. Dr. Wallace specializes in general practice.

❖ **Scott G. Westfall, M.D.,** 224 S. Woods Mill Rd., Chesterfield, MO, has become a member of the St. Louis Metropolitan Medical Society. Dr. Westfall received his medical degree at Indiana University, Indianapolis, IN, in 1984. He completed his residency at St. Louis University. Dr. Westfall specializes in general surgery.

❖ **Paul L. Weygandt, M.D.,** 10 W. Nifong, Columbia, MO 65203, has become a member of the Boone County Medical Society. Dr. Weygandt received his medical degree at the University of Cincinnati, Cincinnati, OH, in 1979. He completed his residency at Akron City Hospital. Dr. Weygandt specializes in orthopedic surgery.

❖ **Stanley D. Wiggins, M.D.,** 3231 S. National, Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Wiggins received his medical degree at Eastern Virginia Medical School, Norfolk, VA, in 1982. He completed his residency at the University of Texas Medical Branch, Galveston, TX. Dr. Wiggins specializes in internal medicine.

❖ **Kimberly M. Wirths, M.D.,** 3800 S. National #730, Springfield, MO 65807, has become a member of the Greene County Medical Society. Dr. Wirths received her medical degree at the University of Missouri-Kansas City, in 1989. She completed her residency at Cox Medical Center, Springfield, MO. Dr. Wirths specializes in family practice.

❖ **Douglas B. Wyatt, M.D.,** Cape Surgical Clinic, 10 Doctors' Park, Cape Girardeau, MO 63701, has become a member of the Cape Girardeau County Area Medical Society. Dr. Wyatt received his medical degree at Texas Tech University, Lubbock, TX, in 1984. He completed his residency at Conemaugh Valley Memorial Hospital, Johnstown, PA. Dr. Wyatt specializes in general, vascular and thoracic surgery.

❖ **Jay S. Zwibelman, M.D.,** Suite 630, 2900 Baltimore, Kansas City, MO 64108, has become a member of the Metropolitan Medical Society of Greater Kansas City. Dr. Zwibelman received his medical degree at the University of Missouri-Kansas City, in 1986. He completed his residency at the University of Wisconsin, Madison, WI. Dr. Zwibelman specializes in neurology.

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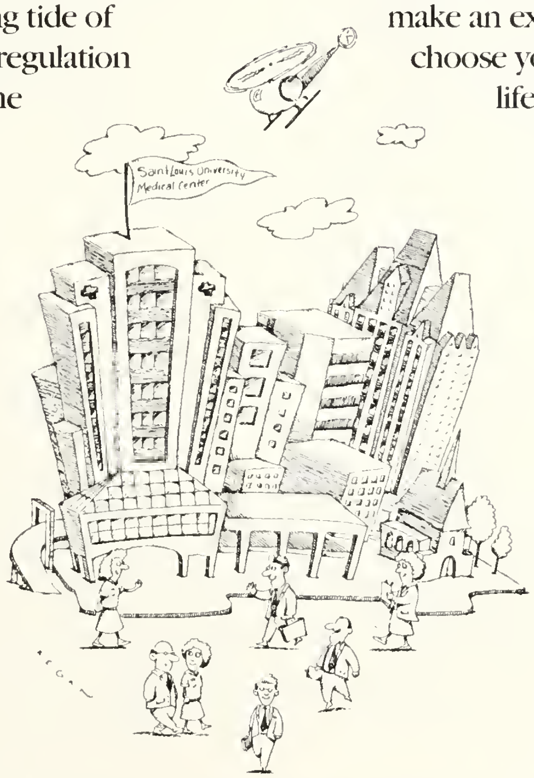
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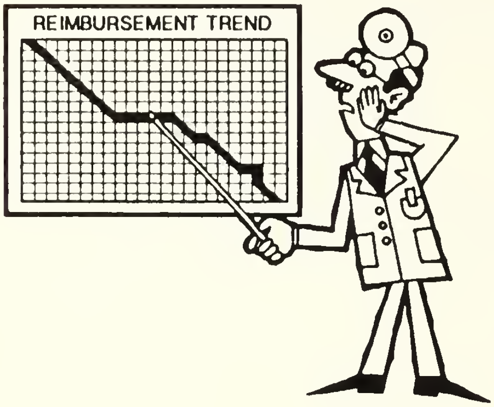

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■ **Richard C. Arnold, MD,** Columbia, Missouri, died October 17, 1992, at the age of 86. Dr. Arnold received his medical degree at the University of Louisville Medical School in 1930. He worked for 31 years with the U.S. Public Health Service, serving three years as assistant surgeon general. In 1943, Dr. Arnold gained international recognition with his discovery of the penicillin cure for syphilis. In 1956 he became the chief of the heart disease control program for the National Institute of Health and made significant contributions to the prevention of heart disease. After retiring from active duty Dr. Arnold served as a consultant to the United Nation's World Health Organization and as medical director of Missouri Crippled Children's Services.

■ **Arthur Bortnick, MD,** University City, Missouri, died September 23, 1992, at the age of 81. Dr. Bortnick received his medical degree at Washington University Medical School in 1935. He was in private practice in St. Louis for 46 years, retiring in 1985. Dr. Bortnick was on staff at Jewish and Barnes hospitals and at the old Homer G. Phillips Hospital. He was an associate professor emeritus at Washington University School of Medicine. Dr. Bortnick was a board member of several groups, including the Jewish Community Centers Association, Temple Israel and the American Parkinson's Disease Association and a member of the American College of Obstetricians and Gynecologists.

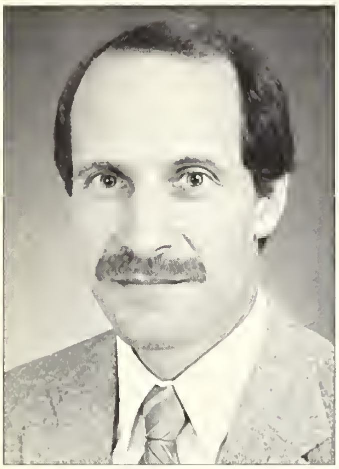
■ **Joseph S. Cope, MD,** Lexington, Missouri, died October 29, 1992, at the age of 82. Dr. Cope received his medical degree at Washington University School of Medicine, St. Louis, Missouri, in 1933. He co-founded the Lexington Medical Clinic and specialized in surgery there until retirement in 1982. Dr Cope conducted a general practice in Kansas City from 1936 to 1942. He was a member of the Hunt, Cummins & Cope surgical group in Kansas City from 1949 to 1954. He was past chief of surgery at the Lexington Memorial Hospital and Ray County Memorial Hospital, Richmond, and had served on the surgical staff of Research Hospital in Kansas City. He had served on the board of directors of the Community Blood Center of Greater Kansas City and Blue Cross and Blue Shield of Kansas City. He was vice president of the Missouri State Medical Association in 1980. Dr. Cope was appointed to the Board of Registration for the Healing Arts in 1974. He was a fellow of the American College of Surgeons and the International College of Surgeons and a charter member of the Southwestern Surgical Congress. He was also a member of the American Society of Abdominal Surgeons.

■ **Nathaniel Goodman, MD,** St. Louis, Missouri, died October 23, 1992, at the age of 81. Dr. Goodman received his medical degree at the University of Edinburgh, Scotland in 1939. He served with a medical unit in the Pacific theater during World War II. After the war he resumed his practice at Christian Hospital Northwest, Christian Hospital Northeast, Incarnate Word Hospital and Faith Hospital, until retirement in 1980.

■ **Joshua Jensen Sr., MD,** Foristell, Missouri, died October 30, 1992, at the age of 80. Dr. Jensen received his medical degree at Washington University in 1938. He was medical director of the St. Louis Police Department for 30 years. Dr. Jensen was chief of staff at Christian Hospitals and at Missouri Baptist Hospital. During World War II, he served with the 70th General Hospital, which traveled to southern Italy and North Africa. In 1947, Dr. Jensen started a private practice in St. Louis County.

■ **Norman K. Muschany, MD,** St. Louis, Missouri, died October 9, 1992, at the age of 68. Dr. Muschany received his medical degree at Temple University School of Medicine, Philadelphia, Pennsylvania, in 1951. He started his career as a general physician in Troy, Missouri. After completing his residency in obstetrics-gynecology he started a private practice in St. Louis. Dr. Muschany was an emeritus associate professor of clinical obstetrics and gynecology at Washington University. He was past president of the Barnes and Allied Hospitals Society, Medical Staff Association at St. Luke's Hospital and the St. Louis Maternity Hospital Society. He was a fellow of the American College of Obstetricians and Gynecologists.

University of Missouri-Columbia



Gregory J. Renner, MD

Gregory J. Renner, MD, associate professor of otolaryngology, recently became the first Missouri recipient of an American Cancer Society Professorship in Clinical Oncology, which includes funding over a five-year period.

Funds will be used to develop and emphasize a multidisciplinary approach in the cancer care and management curriculum at the school.

Dr. Renner was selected after an on-site visit by representatives of a National ACS subcommittee which was impressed with his strong teaching interest and long history in involvement with the ACS. Other factors in the selection are the upcoming conversion of the school's conversion from traditional curriculum to problem-based learning and the merger of the Ellis Fischel Cancer Center with the MU Health Sciences Center.

Only seven ACS professorships have been awarded nationwide, and 20 such professorships are currently in effect.

William T. Griffin, MD

William T. Griffen, MD, professor emeritus and faculty member in the department of obstetrics and gynecology has been awarded the 1992 Jane Hickman Teacher of the Year Award by the University of Missouri-Columbia School of Medicine.

Virginia Huxley, PhD, associate professor of physiology, has been appointed to the Cardiovascular and Renal Study Section of the National Heart, Lung and Blood Institute. The section, composed of 15 established researchers, meets three times a year to review and grant applications throughout the country.

Joseph Janicki, PhD, professor of cardiology, recently gave presentations on myocardial collagen and left ventricular diastolic dysfunction to the Federation of Brazilian Societies for Experimental Biology, the Excola Paulista de Medicina in Sao Paulo and at INCOR, Brazil's largest heart institute. He delivered the keynote lecture at the 10th International Conference of the Cardiovascular System Dyanmic Society in Kobe, Japan and gave an invited lecture during a satellite symposium in Fukushima, Japan.

Nephrology faculty led by **Karl D. Nolph, MD,** professor and director, recently chaired six sessions and gave 13 presentations at the Sixth Congress of the International Society for Peritoneal Dialysis in Thessaloniki, Greece. **Zbylut Twardowski, MD, PhD,** professor of nephrology, also delivered lectures at the 25th Anniversary Symposium of the Columbian Society of Nephrology in Paipa, Columbia, and to the Third Congress of the Panamerican Dialysis and Transplantation Society at the First Venezuelan Congress of Transplantation in Caracas, Venezuela.

Merck Sharpe and Dohme pharmaceutical company made a contribution to the School of Medicine's Office of Continuing Education and Extension for the Health Professions. The unrestricted funds will be used to deliver outreach continuing medical education to rural Missouri physicians in their communities.

St. Louis University

St. Louis University School of Public Health, established in 1991, has become one of 26 accredited public health schools in the country after receiving formal accreditation from the Council on Education for Public Health in October. The accreditation makes it the only such school in Missouri.

Washington University

Chronic fatigue syndrome may be in the news more than it is in the general population. A Washington University study discovered many people complaining about fatigue with only a few actual cases of CFS - 7.4 in 100,000.

Researchers applied Centers for Disease Control (CDC) criteria for the syndrome to existing data from mental health interviews with more than 13,500 people surveyed for the Epidemiologic Catchment Area Program (ECA). CDC criteria symptoms include; persistent and debilitating fatigue of six months or more resulting in a significant reduction in routine activities, mild fever, sore throat, painful lymph nodes, general muscle weakness and discomfort, prolonged fatigue, headache, joint pain, and neuropsychological complaints such as transient visual problems, forgetfulness, slow thinking, depressed mood and sleep disturbances. CDC criteria excludes CFS as the diagnosis if an accompanying medical or psychiatric condition might explain the fatigue.

Only one person met the diagnosis for chronic fatigue syndrome. Less than one-quarter of the study population had experienced fatigue lasting two weeks or more, and in about half of that group, the fatigue was explained by physical illness or medication. Ninety percent of the population had a medical or psychiatric condition, which excluded them from qualifying for a CFS diagnosis.

While the results are preliminary, the findings are consistent with other studies.

Oral cancer patients having undergone tongue removal have a chance at improved life with a new tongue replacement technique. The technique involves grafting a flap of skin and muscle from the latissimus dorsi, the area near the shoulder blade, to make a new tongue.

The latissimus dorsi makes an ideal tongue substitute because it has sufficient bulk to fill the void in the mouth, it has a good artery and vein so that the tissue can be revascularized, and it is a muscle with a nerve that can be used for speaking, swallowing and breathing. Also, this muscle's normal function is to pull the arm backward in a movement such as freestyle swimming and is not often used in daily life.

Bruce H. Haughey, MB, ChB, assistant professor of otolaryngology at the medical school and director of otolaryngology at Jewish Hospital reported preliminary results of 15 patients who have received this procedure to the Third International Conference on Head and Neck Cancer in San Francisco.

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CME CALENDAR

The continuing medical education accreditation program of the MSMA has full approval by the AMA's Council on Medical Education. The institutions and functions listed here qualify for Category I credit for the AMA Physician's Recognition Award. All accredited institutions in Missouri are invited to send this information for listing in *MISSOURI MEDICINE*. Please remember to include the name of the individual who can be contacted at your institution for additional information about your CME events.

December

Every week Oct. 5, 1992 to Oct. 1, 1993. AIDS, Malpractice, OSHA and Medicare. 28 resort-based classrooms. Contact American Educational Institute, Inc., 401 S. Woodward, Suite 333, Birmingham, MI 48009, 800/354-3507, fax 313/433-0615.

4 & 5 - *Kansas City*: Orthopedics for the Primary Care Physician. Category 1 credit hours not approved at this time. Contact Carol Osborne, CME Office, St. Luke's Hospital of Kansas City, 816/932-3737.

5 - *St. Louis*: Hypertension. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

8 & 9 - *St. Louis*: Transesophaeal Echocardiography Course. 13 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

10 to 12 - *St. Louis*: Missouri Cardiovascular. Contact Barry Kling, University of Missouri-Columbia, CME Office, MA215 Health Sciences Center, 314/882-4105.

10 to 13 - *St. Louis*: Practical Anatomy & Surgical Technique Workshop: Craniofacial Surgery. 28 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

11 - *St. Louis*: Mini-Symposium: Frontiers in Extracellular Matrix Biology and Genetci Skin Disease, in honor of Arthur Z. Eisen, M.D. Contact Washington University School of Medicine, Division of Dermatology, Campus Box 8123, 660 S. Euclid Ave., St. Louis, MO 63110.

11 - *Kansas City*: Medical Ethics, Practical Issues. 6.25 credit hours. Contact The Ed Bixby Institute for Postgraduate Medical Education, Research Medical Center, 2316 East Meyer Blvd., Kansas City, MO 64132, 816/276-4306, Toll free, in Missouri, 800/892-5771, ext. 4306, bordering states, 800/821-5140, ext. 4306.

12 - *St. Louis*: Management of Hypercholesterolemia: Goals & Strategies. 4.5 credit hours. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

12 - *St. Louis*: 4th Annual St. Louis University Symposium for Medical Directors in Nursing Homes. 6 credit hours. Contact Sue Wheat, St. Louis University School of Medicine, 314/577-8462.

14 - *St. Louis*: Trauma Imaging. City-Wide Radiology Conference by Stuart E. Mirvis, M.D. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

January

9 or 10 - *St. Louis*: Ophthalmic Microsurgery Workshop Series - Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic. 7 credit hours. Contact Dr. Assil, Bethesda Eye Institute, 314/577-8264.

15 to 17 - *St. Louis*: Advanced Trauma Life Support Course. 24 credit hours. Contact Mary Keegan, R.N., St. Louis University School of Medicine, 577-8365.

11 - *St. Louis*: City-Wide Radiology Conference. For more information contact R. Gilbert Jost, M.D., Chief of Diagnostic Radiology, Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

21 to 23 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop: Thoracolumbar Spine Surgery, An Atlas. 20 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

27 - *St. Louis*: 5th Annual Joseph E. Flynn Lecture Series in Surgery. 4 credit hours. Contact St. John's Mercy Medical Center, 615 S. New Ballas Rd., St. Louis, MO 63141-8277, 314/569-6290.

25 to 29 - *St. Louis*: Medicolegal Death Investigator Training Course. 33 credit hours. Contact Mary Fran Ernst, St. Louis University, 314/522-6410, ext. 6509.

February

6-7-20 *St. Louis*: Ophthalmic Microsurgery Workshop Series - Modern Keratorefractive Surgery: A Safe, Comprehensive Approach to Radial and Astigmatic. 7 credit hours. Contact Dr. Assil, Bethesda Eye Institute, 314/577-8264.

6 & 7 - *St. Louis*: Advanced Cardiac Life Support Provider/Recertification Course. 16 credit hours. Contact the St. Louis University School of Medicine, CME Office at 314/577-8167 or 800/553-2712.

8 - *St. Louis*: 7th Annual Daniel R. Biello Memorial Lecture by Richard Wahl, M.D., "New Horizons in Oncologic Nuclear Medicine." For more information contact the Mallinckrodt Institute of Radiology, 510 South Kingshighway, St. Louis, MO 63110, 314/362-7130.

25 to 27 - *St. Louis*: Practical Anatomy and Surgical Technique Workshop: Temporal Bone Surgical Dissection - Exploring New Surgical Instrumentation with Midas Rex Hands-On Workshop. 16 credit hours. Contact the St. Louis University School of Medicine, CME Office, 314/577-8167 or 800/553-2712.

27 - *St. Louis*: Women and Men in Health Care. Contact Office of CME, Washington University School of Medicine, Campus Box 8063, 660 S. Euclid Ave., St. Louis, MO 63110-1093, 314/362-6893 in Missouri, 800/325-9862 Interstate.

Statement of Ownership, Management and Circulation

1. Title of Pulication: Missouri Medicine
2. Date of Filing: September 30, 1992
3. Frequency of Issue: Monthly

3A. No. of Issues published annually: 12
3B. Annual subscription price: $20.00

4. Location of known office of publication:
   113 Madison, P.O. Box 1028,
   Jefferson City, MO 65102
5. Location of the headquarters or general business office of the publishers:
   113 Madison, P.O. Box 1028,
   Jefferson City, MO 65102
6. Names and complete addresses of publisher, editor, and managing editor:
   Publisher, Royal O. Cooper,
   Executive Vice President
   Missouri State Medical Association
   113 Madison, P.O. Box 1028,
   Jefferson City, MO 65102
   Editor, J. Regan Thomas, M.D.
   113 Madison, P.O. Box 1028,
   Jefferson City, MO 65102
   Managing Editor, Dennis L. Weiser
   113 Madison, P.O. Box 1028,
   Jefferson City, MO 65102
7. Owner: Missouri State Medical Association
   113 Madison, P.O. Box 1028,
   Jefferson City, MO 65102
8. Known Bondholders, Mortgages, and other security holders: None
9. The purpose, Function, and nonprofit status of this organization and the exempt status from Federal income tax purposes has not changed during preceding 12 months.

10. Extent and Nature of Circulation:	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
A. Total number copies printed (Net press run)	6,986	6,854
B. Paid circulation Sales through dealers and carriers, street vendors and counter sales	None	None
Mail Subscriptions	6,804	6,740
Total paid circulation	6,804	6,740
Free distribution by mail samples, complimentary, carrier or other means	None	None
Total distribution	6,804	6,740
Copies not distributed Office use, left over over, unaccounted, spoiled after printing	182	114
Returns from news agents	None	None
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Dennis L. Weiser, Managing Editor

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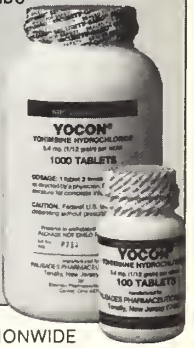
References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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In addition, in view of The Copyright Revision Act of 1976, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: **"In consideration of the Missouri State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA."** We regret that transmittal letters not containing the foregoing language signed by all authors of the submission will necessitate delay in review of the manuscript. Please include the title of the article in the transmittal letter.

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References should be cited in numerical order in the text and arranged at the end of the article in the same order in which they are cited. The reference should give name of author, title of article, name of periodical, volume number, initial page number and year. Authors are responsible for reference accuracy.

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Reprint order blanks will accompany proof, and sent to authors prior to publication.

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Editorials should be written in clear, concise language. Length should be about two or three pages typed with double spacing. Letters will be published at the discretion of the editor, managing editor, and Editorial Board.

Deadlines

All material other than scientific should be received prior to the first of the month preceding month of publication.

INDEX TO ADVERTISERS

Air Force 859
Army 826
CompHealth 859
Eli Lilly & Co. 870
HealthCare Administrative Services 864
Healthline Management, Inc. 863
Jackson & Coker 872
Medical Defense Associates 875
Medical Protective Company 834
MOMEDICO 822
MonetaMed 824
N A & C 832
National Data Bank Response 867
Palisades Pharmaceuticuals 869
PIE Mutual Insurance Co. 874
Physicians International 871
Physicians Who Care 858
RCA Mutual Insurance 840
Sedgwick James of Missouri 860

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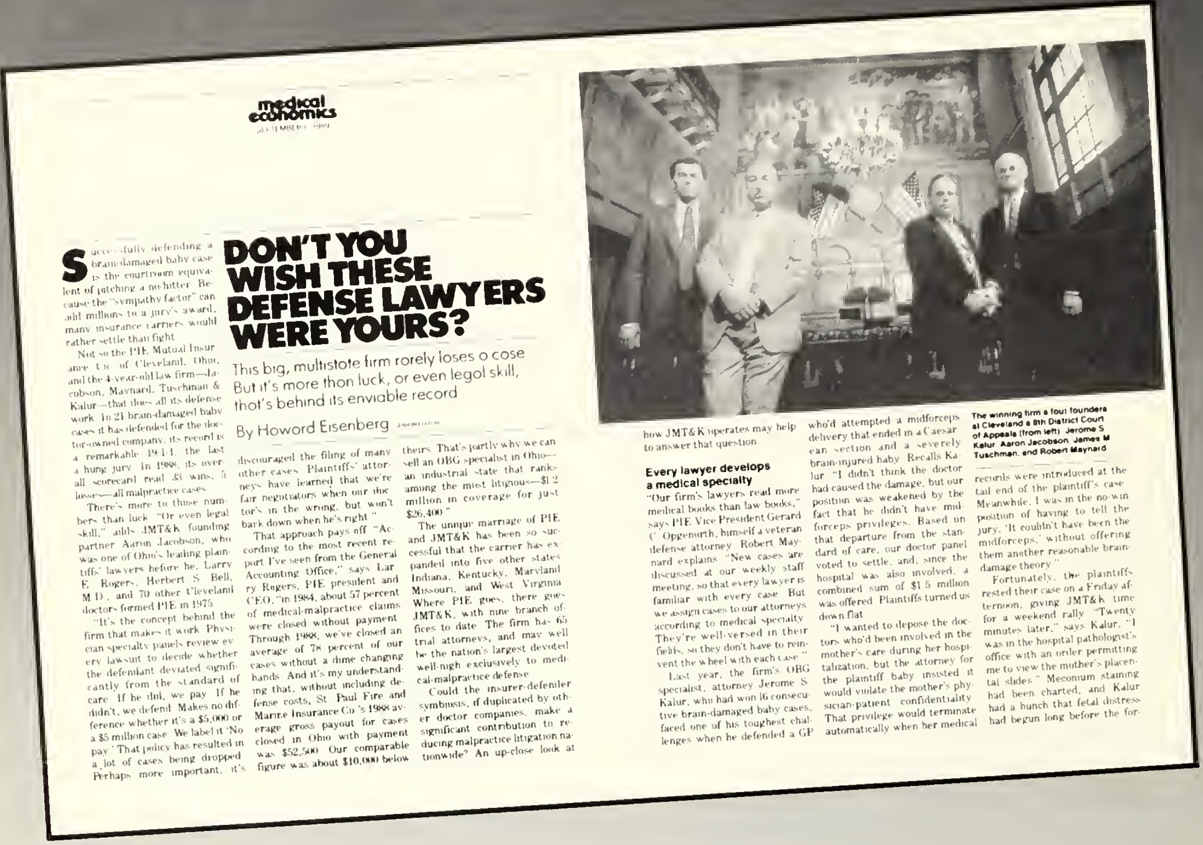

medical economics

SEPTEMBER [illegible] 1989

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case But it's more than luck, or even legal skill, that's behind its enviable record

By Howard Eisenberg [illegible]

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight

Not so the PIE Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988, its overall scorecard read 83 wins, 5 losses—all malpractice cases

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed PIE in 1975

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a $5,000 or a $5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, PIE president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was $52,500. Our comparable figure was about $10,000 below

theirs. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—$1.2 million in coverage for just $26,400."

The unique marriage of PIE and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where PIE goes, there goes JMT&K, with nine branch offices to date. The firm has 65 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical-malpractice defense

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at how JMT&K operates may help to answer that question

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says PIE Vice President Gerard C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP who'd attempted a midforceps delivery that ended in a Caesarean section and a severely brain-injured baby. Recalls Kalur: "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of $1.5 million was offered. Plaintiffs turned us down flat

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left) Jerome S Kalur, Aaron Jacobson, James M Tuschman, and Robert Maynard

records were introduced at the tail end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain-damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-

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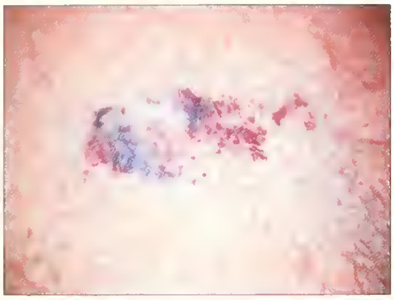
DERMATOLOGY QUIZ (No. 2)

Test your diagnositic skill. Read the report below and make your diagnosis.

Several options are printed at the bottom of this page; correct answer and treatment information may be found on page 857.



A twenty-two year old man awoke 36 hours prior to our examination with fever, chills, vague low back pain, and a tender left thigh. He told us of a blue spot on his inner left thigh with diffuse redness and itching of his trunk and his proximal extremities. He attended an outpatient general medical clinic for initial evaluation, where a "mono-spot" test was administered. The result was negative. He was informed that he had a viral syndrome, and began to receive amantadine and ketoprofen. The symptoms did not improve even after several doses of these medications. He slept only with difficulty and noted enlargement of the spot on his thigh as well as an increase in pain. The generalized redness also worsened. He came to the emergency room for evaluation.

He has a history of contact dermatitis to poison ivy, but doesn't recall being exposed recently. He is not on any chronic medications, and he has no drug allergies.

By physical examination, the young man was found to be moderately uncomfortable. His vital signs were stable. He was afebrile. His skin was generally erythrodermic with more intense erythema on the trunk and proximal extremities. On his medial left thigh was a 2cm by 4cm blue, ecchymotic macule, surrounded by a 5cm by 5cm area of blanched skin without vesicles. He had no cervical, inguinal or axillary adenopathy. The cardio-respiratory and abdominal exams were normal. A complete blood count, urinalysis, PT, PTT and ESR were all within normal ranges. A photograph of the thigh lesion is shown above.

??? Your Diagnosis ???

1. Allergic contact dermatitis with dissemination?
2. Impending disseminated intravascular coagulation?
3. *Loxosceles reclusa* bite?
4. Non-specific viral syndrome?
5. Tularemia?

See Page 857 for diagnosis and treatment discussion.

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